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No.

In the Supreme Court

of the United States

OCTOBER TERM, 1982

OREGON PHYSICIANS' SERVICE, an Oregon nonprofit corporation; and PHYSICIANS' ASSOCIATION OF CLACKAMAS COUNTY, an Oregon nonprofit corporation,
Petitioners,

v.

JOHN HAHN, WADE LIGGETT, JOSEPH AIZAWA, V. G. LIVINGSTON and D. HUGH FRASER,
Respondents.

APPENDIX TO PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

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App. A

John HAHN, Wade Liggett, Joseph Alizawa, et al., Plaintiffs-Appellants,

v.

OREGON PHYSICIANS SERVICE, et al., Defendants-Appellees.

John HAHN, V. G. Livingstone, Hige Aizawa, et al., Plaintiffs-Appellants,

v.

Josephine M. DRISCOLL, Acting Insurance Commissioner of the State of Oregon, Defendants-Appellees,

Lawrence HELTON, David Hoyal, Wade Liggett, et al., Plaintiffs-Appellants,

v.

ROGUE VALLEY PHYSICIANS' SERVICE, et al., Defendants-Appellees.

Lawrence HELTON, David Hoyal, et al., Plaintiffs-Appellants,

v.

GREATER OREGON HEALTH SERVICES, Defendant-Appellee.

No. 81-3173.

United States Court of Appeals, Ninth Circuit.

Argued and Submitted March 4, 1982.
Decided Oct. 5, 1982.

Appeal from the United States District Court for the District of Oregon.

Before KENNEDY, FARRIS and NORRIS, Circuit Judges.

FARRIS, Circuit Judge:

Plaintiff-podiatrists filed four separate actions in September 1978 alleging that the defendants conspired or combined to boycott podiatrists in favor of other physicians in violation of the Clayton Act, 15 U.S.C. § 12 et seq., and the Sherman Act, 15 U.S.C § 1 et seq. After initial discovery the defendants moved for summary judgment and the district court granted the motion on February 27, 1981. Hahn v. Oregon Physicians' Service, 508 F.Supp. 970 (D.Or.1981). We reverse and remand for further proceedings.

I. FACTS

Plaintiffs are doctors of podiatric medicine licensed to practice in Oregon. Or.Rev.Stat. § 682.020. Defendants are providers of prepaid health insurance. The defendants include state regulated health care contractors, Or.Rev.Stat. § 750.005(2)(a); federally regulated health maintenance organizations, 42 U.S.C. § 300e; and a federally regulated individual practice association, 42 U.S.C. § 300e-1(5). The plaintiffs challenge three of the defendants' practices: (1) insureds are

required to obtain certain podiatric services exclusively from medical doctors; (2) insureds are not reimbursed for treatment by a podiatrist unless they are referred by an M.D.; and (3) podiatrists are not allowed to be members of defendant health-care associations. The effect of the latter practice is that podiatrists are reimbursed for their services at a lower rate than are members of the defendant organizations.

The district court granted the defendants' summary judgment motion, finding that the McCarran-Ferguson Act, 15 U.S.C. § 1011 et seq., exempts defendants from antitrust liability and that the plaintiffs failed to meet the interstate commerce jurisdictional requirement of the Sherman Act.

II. DISCUSSION

A. McCarran-Ferguson Act

The threshold issue is whether the district court was correct in finding the challenged activities of the defendant health-care providers exempt from antitrust laws under the McCarran-Ferguson Act, 15 U.S.C. § 1012(b). We reverse this ruling. The exemption is inapplicable upon the facts in issue.

1) Introduction

The primary purpose of the McCarran-Ferguson Act is to allow for state regulation of the activities of insurance companies. 15 U.S.C. § 1011 et seq. A secondary purpose is to give insurance companies limited immunity

from antitrust laws. See Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205, 218 & n.18, 99 S.Ct. 1067, 1077 & n.18, 59 L.Ed.2d 261 (1979). To qualify for an exemption from the federal antitrust laws, the anticompetitive practices 1) must be part of the "business of insurance," 2) must be regulated by state law, and 3) may not take the form of coercion, intimidation, or boycott. See 15 U.S.C. §§ 1012(b) and 1013(b). The pivotal question is whether the defendants' activities were part of the "business of insurance."

2) Precedent

The Supreme Court limited the scope of the antitrust exemption in Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205, 99 S.Ct. 1067, 59 L.Ed.2d 261 (1979), by narrowly defining the statutory term "business of insurance." The Court recently reaffirmed this holding. Union Labor Life Insur. Co. v. Pireno, ___ U.S. ___, ___, ___, 102 S.Ct. 3002, 3006-08, 73 L.Ed.2d 647 (1982). In Royal Drug independent pharmacists filed an antitrust action against Blue Shield, a health insurer, and several participating pharmacies challenging provider-agreements. The defendants contended that the provider contracts were not subject to the federal antitrust laws because the provider contracts constituted the "business of insurance" and were therefore exempt under the McCarran-Ferguson Act. The Supreme Court disagreed and in its ruling

adopted a narrow interpretation of the statutory language, the "business of insurance."

In holding that the pharmacy agreements were not the "business of insurance" within the meaning of § 2(b), the Court based its ruling in part on the common understanding of that term. Royal Drug, 440 U.S. at 211, 99 S.Ct. at 1073. The Court identified three relevant criteria for determining if a business practice is part of the "business of insurance:" "first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry." Union Labor Life Insurance Co. v. Pireno, ___ U.S. ___, ___, 102 S.Ct. 3002, 3008, 73 L.Ed.2d 647 (1982). See also Royal Drug, 410 U.S. at 211-12, 215, 231, 99 S.Ct. at 1073, 1075, 1083.

The insurance contract involves a contractual relationship which exists when an insurer, for consideration, agrees to reimburse an insured for loss caused by designated contingencies. See Black's Law Dictionary 721 (5th Ed. 1979). This underwriting and subsequent spreading of the policyholder's risk is the primary element of the insurance contract and is, therefore, the "business of insurance." Royal Drug, 440 U.S. at 211, 99 S.Ct. at 1073. The Court in Royal Drug recognized that the provider contracts neither served to

spread the risk nor to define the peril, but were merely a cost-cutting device for the insurers. Id. at 214-15, 99 S.Ct. at 1074-75. The provider contracts established an "arrangement for the purchase of goods and services" that reduced the insurer's cost of covering the loss that it was obligated to cover under the insurance contract. Id. at 214, 99 S.Ct. at 1074.[1] The Court concluded that this primary element of risk-spreading was missing in the provider agreements.

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1 The Court rejected the argument that the contested activity so closely effected Blue Shield's reliability so as to constitute the "business of insurance." The court stated:

> [E]very business decision made by an insurance company has some impact on its reliability, its ratemaking, and its status as a reliable insurer. If terms such as "reliability" and "status as a reliable insurer" were to be interpreted in the broad sense urged by the petitioners, almost every business decision of an insurance company could be included in the "business of insurance." Such a result would be plainly contrary to the statutory language, which exempts the "business of insurance" and not the "business of insurance companies."

Royal Drug, 440 U.S. at 216-17, 99 S.Ct. at 1075-76.

The Court in Royal Drug also found that the provider agreement was not an "integral part of the contract between the insurer and the insured," 440 U.S. at 215-16, 99 S.Ct. at 1075, and that it involved entities outside the insurance industry. Id. at 224, 231, 99 S.Ct. at 1080, 1083. See Pireno, ___ U.S. at ___, 102 S.Ct. at 3008.

Circuit courts have consistently applied the narrow definition of "the business of insurance" enunciated in Royal Drug. In an analogous case, Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia, 624 F.2d 476 (4th Cir. 1980), cert. denied, 450 U.S. 916, 101 S.Ct. 1360, 67 L.Ed.2d 342 (1981), an organization of psychologists and an individual practicing psychologist brought a Sherman Act action against Blue Shield plans and a medical society because the plans refused to reimburse insureds for services rendered by clinical psychologists unless the services were billed through a physician. The court held that the defendants' activities were not the "business of insurance." Id. at 483-84. The court recognized that the insurers had already made the underwriting decision to cover these mental and nervous disorders in their policies. "Their decision regarding psychologists was not whether to underwrite the risk of those disorders or even the need for psychotherapy; rather it was a question of who [sic] they would pay for such services." Id. at 484. The court therefore decided that the defendants' actions did not fall within the traditional meaning of

the "business of insurance" but rather related to the cost of carrying out their contractual obligation. Other cases since Royal Drug support the interpretation that only the core activities of a traditional insurance company, viz., the underwriting and risk spreading functions, fall within the McCarran-Ferguson Act exemption for the business of insurance.[2]

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2 We note that other courts have recognized that certain health-care provider organizations may not fall within the McCarran-Ferguson Act's definition of the "business of insurance." The Supreme Court stated in Royal Drug that at the time of the enactment of the McCarran-Ferguson Act, organizations which were organized to provide their members with health care and hospitalization services were not considered to be engaged in the insurance business. 440 U.S. at 225-30 & n.33, 99 S.Ct. at 1080-82 & n.33. The Court, however, found it unnecessary to decide this issue. Id. See also Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia, 624 F.2d 476, 483 (4th Cir. 1980), cert. denied, 450 U.S. 916, 101 S.Ct. 1360, 67 L.Ed.2d 342 (1981) (exemption should be narrowly applied to Blue Shield plans, especially where provider control is at issue).

Prepaid health care provider plans are difficult to analyze because they go beyond the normal insurance

3) Refusal to Cover Podiatrists and the "Business of Insurance"

Relying on the facts that podiatrists are prohibited by statute from providing certain services that M.D.'s may provide and that the Oregon legislature has not enacted an "equality of insurance" statute for podiatrists, the district court concluded that the exclusion of podiatrist services is an integral part of the risk of covering care to the foot. 508 F.Supp at 974-75. The record does not support this conclusion.

The defendants have introduced no evidence tending to establish that there are any bona fide risk-related reasons for an insured to distinguish between the services of M.D.'s and podiatrists, much less that such a distinction is at the core of what is commonly understood to be the "business of insurance." One may doubt whether the insurance provision legitimately relates to the underwriting or spreading of risk by an insurer. Of particular

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(Footnote 2 continued)

> function of insuring against specific casualty losses, and may also provide routine health care services. Courts should be careful not to allow insurance companies to broaden the antitrust exemption by simply diversifying into areas not traditionally considered to be the business of insurance.

importance to the case here, "it is plain that the challenged . . . practices are not limited to entities within the insurance industry." Pireno, ___ U.S. at ___, 102 S.Ct. at 3010, 73 L.Ed.2d 647. As the Supreme Court noted in that case, the McCarran-Ferguson exemption "was intended primarily to protect 'intra-industry competition' in the underwriting of risks. . . Arrangements between insurance companies and parties outside the insurance industry can hardly be said to lie at the center of that legislative concern. More importantly, such arrangements may prove contrary to the spirit as well as the letter of [the exemption] because they have the potential to restrain competition in non-insurance markets. The peer review practices challenged in the present case assertedly realize precisely this potential: Respondent's claim is that the practices restrain competition in a provider market--the market for chiropractic services--rather than in an insurance market." Id. Although the Supreme Court did not hold that effect on non-insurance markets was in itself sufficient to negate the applicability of the McCarran-Ferguson exemption, arrangements whose primary impact is on competition in markets other than that for insurance do not fall within the exemption. Since this is the case here, the appellees cannot claim the benefit of the McCarran-Ferguson exemption.

The ruling of the district court, allowing the McCarran-Ferguson exemption as a defense, is reversed.

B. Interstate Commerce

The district court also found that the plaintiffs had failed to meet the interstate commerce jurisdictional requirement of the Sherman Act. We disagree.

Jurisdiction under the Sherman Act extends not only to activities actually in interstate commerce, but also to activities wholly local in nature that substantially affect interstate commerce. McLain v. Real Estate Bd., Inc., 444 U.S. 232, 237, 241, 100 S.Ct. 502, 506, 508, 62 L.Ed.2d 441 (1980). McLain sets forth a two-part analysis for determining if the commerce requirement was satisfied.

> First, a relevant aspect of interstate commerce must be identified. Second, the defendants' activities must be shown "'as a matter of practical economics' to have a not insubstantial effect on the interstate commerce involved."

Palmer v. Roosevelt Lake Log Owners Ass'n, Inc., 651 F.2d 1289, 1291 (9th Cir. 1981).

In McLain real estate purchasers and sellers alleged a conspiracy by real estate brokers to fix real estate commissions. The McLain Court began its analysis by stating that, to establish subject matter jurisdiction, it is sufficient to demonstrate that defendants' relevant activities have a "not insubstantial effect" on interstate commerce. 444 U.S. at 242, 246, 100 S.Ct. at 509, 511. At the

jurisdictional stage plaintiffs need not make a more particularized showing that the allegedly unlawful restraint (in McLain, the alleged price fixing scheme) itself affects interstate commerce. Id. at 242, 246, 100 S.Ct. at 509. The Court emphasized that more was not required. "If establishing jurisdiction required a showing that the unlawful conduct itself had an effect on interstate commerce, jurisdiction would be defeated by a demonstration that the alleged restraint failed to have its intended anticompetitive effect." Id. at 243, 100 S.Ct. at 509.

The district court misapplied the McLain analysis. First, the district court did not identify the relevant line of commerce. More importantly, the district court focused its inquiry exclusively on the nature and extent of plaintiffs' interstate contacts, concluding that, because plaintiffs' interstate activities are insubstantial, defendants' activities could not substantially affect them. Hahn v. Oregon Physicians Service, 508 F.Supp. 970, 977 (D.Or.1981).

The plaintiffs' interstate contacts are relevant because the jurisdictional requirement may be satisfied by showing that defendants' activities affect interstate commerce through their effect on plaintiffs' interstate activities. See, e.g., Hospital Building Co. v. Trustees of Rex Hospital, 425 U.S. 738, 96 S.Ct. 1848, 48 L.Ed.2d 338 (1976). However, if the plaintiffs' interstate contacts are insubstantial, jurisdiction may also be

established directly by the defendants' activities. The trial court must conduct a broader inquiry into the defendants' activities to ascertain whether they themselves affect interstate commerce. We thus remand for identification of a relevant aspect of interstate commerce and a determination whether defendants' relevant insurance activities, taking into account their overall effect on interstate commerce and not simply their effect on the particular plaintiffs before the court, have, as a matter of practical economics, a "not insubstantial effect" on interstate commerce.

REVERSED and REMANDED.

John HAHN, Wade Liggett, Joseph Aizawa, V. G. Livingston, and D. Hugh Fraser, Plaintiffs,

v.

OREGON PHYSICIANS' SERVICE, an Oregon nonprofit corporation and Physicians' Association of Clackamas County, an Oregon nonprofit corporation, Defendants.

John HAHN, V. G. Livingston, Hide Aizawa, and D. Hugh Fraser, Plaintiffs,

v.

PORTLAND METRO HEALTH PHYSICIANS, INC., an Oregon nonprofit corporation, and Portland Metro Health, Inc., an Oregon nonprofit corporation, Defendants.

Lawrence HELTON, David Hoyal, Wade Liggett, Elmer Dorr, Hide Aizawa, and Jeffrey L. Widen, Plaintiffs,

v.

ROGUE VALLEY PHYSICIANS' SERVICE, an Oregon nonprofit corporation; and Klamath Medical Service Bureau, an Oregon nonprofit corporation, Defendants.

Lawrence HELTON, David Hoyal and Jeffrey Widen, Plaintiffs,

v.

GREATER OREGON HEALTH
SERVICES, Inc., Defendant.

Civ. Nos. 78-0887, 79-0191, 79-0199
and 79-0200.

United States District Court,
D. Oregon

Feb. 27, 1981.

SOLOMON, District Judge:

INTRODUCTION

Plaintiffs are Doctors of Podiatric Medicine (Podiatrists) licensed to practice in Oregon under ORS § 682.010. In 1978, they filed these actions against the defendants,[1] who are state regulated health care

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1 Present defendants are: Oregon Physicians' Service (OPS), Physicians' Association of Clackamas County (PACC), Rogue Valley Physicians' Service (RVPS), Klamath Medical Service Bureau (KMSB), and Greater Oregon Health Service (GOHS), all health care contractors under ORS § 750.005 et seq.; Portland Metro Health Physicians (PMHP), a federally regulated individual practice association; and Portland Metro Health (PMH), a federally regulated individual practice association.

contractors;[2] a federally regulated Health Maintenance Organization (HMO); and a federally regulated Individual Practice Association.[3]

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2 ORS § 750.005(2)(a) defines "health care service contractor" as:

> Any corporation organized not for profit that is sponsored by or otherwise intimately connected with a group of doctors licensed by this state, or by a group of hospitals licensed by this state, or both which accepts prepayment for health care services. . .

3 HMOs provide basic and supplemental health services to its members for a payment which is paid periodically without regard to the dates health services are provided. Their payment is fixed without regard to the frequency, extent, or kind of service actually furnished. 42 U.S.C § 300e

An "individual practice association" is:

> . . . A partnership, corporation, association, or other legal entity which has entered into a services arrangement (or arrangements) with persons who are licensed to practice medicine . . . podiatry, . . . or other health profession in the state and a majority of whom are licensed to practice medicine or osteopathy . . . 42 U.S.C § 300e-1(5)

Plaintiffs allege that the defendants have conspired or combined to boycott podiatrists' services in favor of physicians licensed by the Oregon Board of Medical Examiners, in violation of the Clayton Act, 15 U.S.C. § 12 et seq., and the Sherman Act, 15 U.S.C § 1 et seq.

Plaintiffs challenge three kinds of practices. They first assert that defendants require their insureds to obtain some podiatric services solely from a Medical Doctor (M.D.). They next assert that defendants' insureds are discouraged from using podiatrists because they are not covered for that care unless they are referred to a podiatrist by an M.D. They also assert that because podiatrists are not members of the defendant health insurers, they are reimbursed for their services to defendants' insureds at a lower rate than are M.D.'s who are members of the defendants.

Defendants seek summary judgment on the following grounds:

1. Defendants are exempt from antitrust liability under the McCarran-Ferguson Act, 15 U.S.C § 1011 et seq.;

2. Defendants are exempt from antitrust liability under the state action doctrine and the governmental immunity doctrine;

3. The court lacks jurisdiction because the acts complained of neither take place in nor affect interstate commerce;

4. State regulatory authorities have exclusive jurisdiction or primary jurisdiction over these claims, and plaintiffs have not exhausted their administrative remedies.

I. McCARRAN-FERGUSON ACT

To qualify for an exemption under the McCarran-Ferguson Act, three conditions must be satisfied. First, the anticompetitive practices must be part of the business of insurance, not merely the business of insurance companies.[4] Second, those practices must be regulated by state law.[5] Third, the anticompetitive

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4 15 U.S.C. § 1011:

> Congress declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.

5 15 U.S.C. § 1012:

> (a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.
>
> (b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any

practices cannot take the form of coercion, intimidation, or boycott.[6]

A. Business of Insurance

Both plaintiffs and defendants rely principally on two cases, Group Life and Health Insurance Co. v. Royal Drug, 440 U.S. 205, 99 S.Ct. 1067, 59 L.Ed.2d 261 (1979) ("Royal Drug"), and Virginia Academy of Clinical Psychologists v. Blue Shield of

(Footnote 5 continued)

State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: Provided, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

6 15 U.S.C § 1013(b):

(b) Nothing contained in this chapter shall render the said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation.

Virginia, 624 F.2d 476 (4th Cir. 1980) ("Virginia Academy").

In Royal Drug, independent pharmacists filed an action against Blue Shield of Texas and three pharmacists who had provider agreements with Blue Shield. Under these agreements, an insured who purchased prescription drugs from a participating pharmacist paid only two dollars for the prescription, and the pharmacist recovered the full price of the prescription from Blue Shield. But an insured who purchased the prescription from a non-participating pharmacist paid the full price, and would then be reimbursed by Blue Shield for 75% of the full price less two dollars.

Any licensed pharmacy could participate, but participation was limited to those pharmacists willing to accept a two dollar markup. Plaintiffs contended that this arrangement was anticompetitive because it discouraged Blue Shield's insureds from using the non-participating pharmacists. An insured using a non-participating pharmacist was required to request reimbursement from Blue Shield, and would pay more for their prescriptions.

The District Court granted Blue Shield's motion for summary judgment based on the McCarran-Ferguson Act exemption. The Supreme Court, when it reversed, ruled that these agreements were not the business of insurance, but only the business of insurance companies.

It defined "business of insurance" as the spreading and

underwriting of risk, and held that although Blue Shield's arrangement with participating pharmacists reduced the cost of prescription drugs for its insureds, Blue Shield did not spread or underwrite an insured's risk. The agreements were not exempt.

This case differs from Royal Drug in two significant aspects. First, the agreements challenged in Royal Drug were not agreements between the insurer and the insured, but agreements between the insurer and the pharmacy-providers. Here, the agreement challenged is the insurance contract between the insurer and the insured. Second, the Royal Drug agreements did not spread or underwrite the risk of providing coverage for prescription drugs; they merely lowered the cost of providing the coverage. Here, the alleged restraints are an integral part of the risk of covering care to the foot.

The risk assumed by defendants, as underwriters of medical care to the foot, is affected by their determination that their risk would be greater if podiatrists were permitted to treat their insureds equally with M.D.'s.

Defendants' conclusion is supported by the licensing provisions for these professions in the Oregon Revised Statutes. Unlike M.D.'s, podiatrists may not perform:

> treatment involving the use of a general or spinal anesthetic unless the treatment is performed in a hospital . . . and is under the

> supervision of or in collaboration with a physician licensed to practice medicine by the Board of Medical Examiners for the State of Oregon. 'Podiatry' does not include the administration of general or spinal anesthetic or the amputation of the foot. ORS § 682.010(3)

Many services may be performed either by podiatrists or by M.D.'s. But there are other services involving the foot which podiatrists may not perform. There is a rational basis for the limitations in the policy on the coverage of podiatric care for their insureds.

In Virginia Academy, plaintiffs, an organization of clinical psychologists, challenged Blue Shield's deliberate refusal to obey a Virginia statute which required health care organizations to pay directly for services rendered by licensed psychologists. Blue Shield would not allow payment for psychotherapy rendered by psychologists unless the treatment was supervised and billed through an M.D. The District Court ruled that the activity was exempt under the McCarran-Ferguson Act, and the Court of Appeals reversed.

The Court of Appeals held that "defendants' conduct was not the 'business of insurance.'" 624 F.2d at 483. The court struck the provisions in the insurance policy which granted reimbursement for care by a psychologist only if the care was billed through an M.D. The court stated that this decision by the insurance company was

not related to coverage for mental or nervous disorders, but only involved who the company would pay for the services rendered in the treatment of such disorders.

This holding and statement must be considered in connection with Virginia's "Freedom of Choice" statute, Va.Code § 38.1-824, which prohibits health insurers from refusing, "directly or indirectly, to allow or pay for . . . services rendered by any . . . psychologist . . . "

The insurance policy covered treatment for mental and nervous disorders, which both psychologists and M.D.'s were licensed to treat, and under Virginia Law, a health insurer may not, in covering its insureds for these disorders, refuse to treat psychologists on the same basis as M.D.'s. Therefore, a provision in an insurance policy which grants its insureds reimbursement for care by a psychologist only if billed through an M.D. violates Virginia law, and the court was justified in striking the offensive provision.

In Oregon, there is no such law affecting podiatrists. On several occasions, podiatrists and other health care professionals, such as dentists, psychologists, nurse practitioners, denturists, and optometrists, have sought similar legislation. Although the Oregon legislature enacted laws to provide equality of insurance treatment for these professionals, podiatrists were not successful in having a similar statute enacted. I believe this is some

evidence that the legislature did not intend to treat podiatrists equally with M.D.'s in connection with insurance reimbursement.

In my view, the qualifications of physicians, podiatrists, and other members of the healing arts, and the nature and extent of the services such persons may perform, are essential elements in the risk which health care insurance companies may legally define. Therefore, the defendants were privileged to determine that the care provided by podiatrists increased the risk over that of an M.D., for the same type of service. this is particularly true in Oregon, where there is no equality statute.

I therefore hold that the decision of the defendants to limit their risk by imposing restrictions on podiatric care insurance qualifies as the "business of insurance" for purposes of the McCarran-Ferguson Act.

B. State Regulation

The second requirement of the McCarran-Ferguson Act is that the business of insurance be regulated by state law. 15 U.S.C. § 1012(b).

Defendants are regulated by the Oregon Insurance Code under ORS § 750.005-.340, the provisions which cover health care contractors. These sections make applicable to defendants many of the regulations to which the business of insurance generally is subject. Section 743.006 requires

insurers to submit their policy forms to the Insurance Commissioner for approval. Section 743.009 requires the Insurance Commissioner to disapprove the policies if they do not comply with law, are prejudicial to the insurer's policy holders, or are unjust, unfair, or inequitable. Subsection 746.160(3) forbids insurance companies from "doing anything which is detrimental to free competition in the business or injurious to the insuring public."

This regulatory scheme satisfies the second requirement of the McCarran-Ferguson Act. Dexter v. Life Assurance Society of the United States, 527 F.2d 233 (2d Cir. 1975); Transnational Insurance Co. v. Rosenlund, 261 F.Supp. 12, 25-26 (D.Or. 1966).

Plaintiffs contend that the McCarran-Ferguson Act does not apply because the Oregon Insurance Code does not specifically regulate the practice of podiatry, or the particular practices in issue here. If the state regulates the business of insurance, and the practices challenged are part of the business of insurance, the failure of the state to react to a particular practice does not affect the application of the McCarran-Ferguson Act. Addrisi v. Equitable Life Assurance Society of the United States, 503 F.2d 725 (9th Cir. 1974), cert. denied, 420 U.S. 929, 95 S.Ct. 1129, 43 L.Ed.2d 400 (1975).

C. Boycott

Plaintiffs contend that even if the defendants meet the first two

requirements of the McCarran-Ferguson Act, they lose the exemption because they are engaged in an illegal boycott. 15 U.S.C. § 1013(b).

To qualify for the boycott provision of the McCarran-Ferguson Act, defendant must have engaged in concerted activity which forecloses competition anywhere in the relevant market. St. Paul Fire and Marine Insurance Co. v. Barry, 438 U.S. 531, 553, 98 S.Ct. 2923, 2935, 57 L.Ed.2d 932 (1978). In Barry, plaintiffs were required to carry medical malpractice insurance, and all access to that insurance was controlled by the defendants.

The facts here do not amount to a boycott. Defendants do not control the health insurance market. There are other health insurers, not defendants in this case, which provide coverage for podiatric services. In addition, insureds under defendants' policies are free to obtain podiatric care without restriction, if they are willing to pay for those services.

Under all the facts, I find there is no boycott. In addition, plaintiffs have failed to present any evidence of concerted action. There is no merit in plaintiff's boycott contention.

I therefore hold that defendants are exempt from anti-trust liability under the McCarran-Ferguson Act. Defendants' motion for summary judgment is therefore granted.

Because of the likelihood that plaintiffs will appeal, I will discuss the other grounds on which defendants base their motion for summary judgment.

II. STATE ACTION IMMUNITY

Defendants contend that they are entitled to antitrust immunity under the state action doctrine.

Immunity from the antitrust laws is available when the anti-competitive activity is "clearly articulated and affirmatively expressed as a state policy," and when that policy is actively supervised by the state itself. California Retail Liquor Dealers Association v. Midcal Aluminum, Inc., 445 U.S. 97, 100 S.Ct. 937, 63 L.Ed.2d 233 (1980).

Defendants contend that a "clearly articulated state policy" supporting their treatment of podiatrists exists because the Oregon Legislature has refused to pass equality legislation for podiatrists, but has passed such legislation for others in the health care fields.[7]

The failure to enact proposed equality legislation is not alone enough to demonstrate a clear state policy favoring the inequality. As the Oregon Supreme Court stated in Berry v.

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7 See: Or.Rev.Stat. §§ 743.052 (dentists); 743.123 (psychologists); 743.128 (nurse practitioners); 743.132 (denturists); 750.065 (optometrists).

Branner, 245 Or. 307, 421 P.2d 996 (1966), where the court was asked to read the legislature's failure to amend a statute as a signal of legislative approval: "Legislative inaction is a weak reed upon which to lean in determining legislative intent." Id. at 311, 421 P.2d 996.

To be entitled to state action immunity, the state's anticompetitive policy must be affirmative, not passive or inferential. Cantor v. Detroit Edison Co., 428 U.S. 579, 96 S.Ct. 3110, 49 L.Ed.2d 1141 (1976). Defendants have not demonstrated a clearly articulated state policy supporting their treatment of podiatrists.

Defendants also contend that the National Health Planning and Resources Development Act of 1974, 42 U.S.C. § 300k et seq., articulates a national policy of discouraging competition in the health insurance field, and that because this policy conflicts with the antitrust laws, defendants should not be subject to the antitrust laws under the implied governmental immunity doctrine.

Defendants have not shown that the Act requires of them conduct which conflicts with the federal antitrust laws. Without this conflict, the implied immunity doctrine is inapplicable. see National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City, 628 F.2d 1050 (8th Cir. 1980), cert. granted, ___ U.S. ___, 101 S.Ct. 938, 67 L.Ed.2d 108 (1981).

I therefore hold that defendants are not entitled to summary judgment based on the state action immunity or under the implied governmental immunity doctrine.

III. INTERSTATE COMMERCE

Defendants contend[8] that there is insufficient interstate commerce to support federal jurisdiction. They assert that their provision of insurance coverage, and plaintiff's podiatric practices, are not in interstate commerce, but are wholly local in character.

Plaintiffs contend that their

(1) out of state purchases of medical supplies and equipment;

(2) treatment of patients who cross state lines;

(3) receipt of payments from out of state insurers; and

(4) participation in the federal medicare program, are adversely affected by defendants' conduct.

To satisfy the "affecting commerce" test for antitrust

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8 This part of the motion for summary judgment is made only by defendants Greater Oregon Health Service, Inc.; Rogue Valley Physicians' Service; and Physicians' Association of Clackamas County.

jurisdiction, plaintiffs must show that defendants' business activities, "as a matter of practical economics," has "a not insubstantial effect on the interstate commerce involved." McLain v. Real Estate Board of New Orleans,Inc., 444 U.S. 232, 246, 100 S.Ct. 502, 511, 62 L.Ed.2d 441 (1980); Hospital Building Co. v. Trustees of Rex Hospital, 425 U.S. 738, 96 S.Ct. 1848, 48 L.Ed.2d 338 (1976). There is no specific quantity associated with the "not insubstantial effect" test. Each case turns on its own facts.

In McLain, supra, the Court found a "substantial effect" because fixed price brokerage fees, although local in character, would stimulate or retard the volume of real estate sales in the New Orleans area, and would consequently affect the "appreciable" volume of out of state financing for those sales. 444 U.S. at 245, 100 S.Ct. at 510. And in Rex Hospital, supra, the plaintiff hospital alleged that its out of state purchases would decrease by "perhaps hundreds of thousands of dollars," and a multimillion dollar financing deal would not take place. 425 U.S. at 744, 96 S.Ct. at 1852.

Plaintiffs assert that their activities involved interstate commerce. But the amount of interstate commerce each plaintiff has alleged is insubstantial. Even if plaintiffs purchased all of their supplies and equipment out of state, the amount is inconsequential compared to their gross income. Fewer than two percent of their patients travel across state lines. And

the largest sum any one of the plaintiffs received from an out of state insurance company is less than 1/2 of 1% of that plaintiff's gross income.

When compared to the volume of interstate commerce that would be affected by the business activities in McLain and Rex Hospital, plaintiffs' alleged interstate commerce is insubstantial. See Thornhill Publishing Co., Inc. v. General Telephone and Electronics Corp., 594 F.2d 730 (9th Cir. 1979). Because plaintiffs' interstate activities are so insubstantial, defendants' business activities could not "as a matter of practical economics," substantially affect them, McLain, supra, at 246, 100 S.Ct. at 512.

I hold that plaintiffs have failed to meet the interstate commerce jurisdictional requirements of the Sherman Act, and that the defendants are entitled to summary judgment on this ground.

IV. EXCLUSIVE JURISDICTION

Defendants contend that the Oregon Insurance Commissioner has exclusive jurisdiction over plaintiff's claims because the claims involve the business of insurance, an area in which Congress has given regulatory authority to the states.

This contention depends on whether the McCarran-Ferguson Act or the state action doctrine is applicable. I have held that defendants' alleged

antitrust violations are covered by the McCarran-Ferguson Act. Therefore, the Oregon Insurance Commissioner has exclusive jurisdiction over plaintiffs' claims, and plaintiffs may follow the procedure set out in the Oregon Insurance Code for bringing complaints about the fairness of defendants' insurance practices.

CONCLUSION

Defendants' motion for summary judgment is granted.

App. C

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

JOHN HAHN, et al.,
Plaintiffs-Appellants,

vs.

OREGON PHYSICIANS SERVICE, et al.,
Defendants-Appellees.

JOHN HAHN, et al.,
Plaintiffs-Appellants,

vs.

JOSEPHINE M. DRISCOLL, etc.,
Defendants-Appellees.

LAWRENCE HELTON, et al.,
Plaintiffs-Appellants,

vs.

ROGUE VALLEY PHYSICIANS' SERVICE,
et al.,
Defendants-Appellees.

LAWRENCE HELTON, et al.,
Plaintiffs-Appellants,

vs.

GREATER OREGON HEALTH SERVICES,
Defendant-Appellee.

No. 81-3173
DC CV 78-887
79-191
79-199
97-200 GJS

APPEAL from the United States District Court for the District of OREGON (Portland).

THIS CAUSE came on to be heard on the Transcript of the Record from the United States District Court for the District of OREGON (Portland) and was duly submitted.

ON CONSIDERATION WHEREOF, It is now here ordered and adjudged by this Court, that the judgment of the said District Court in this Cause be, and hereby is reversed and remanded.

Filed and entered October 5, 1982

App. D

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

JOHN HAHN, WADE LIGGETT,
JOSEPH AIZAWA, et al.,
Plaintiffs-Appellants,

v.

OREGON PHYSICIANS SERVICE, et al.,
Defendants-Appellees.

JOHN HAHN, V.G. LIVINGSTONE,
HIGE AIZAWA, et al.,
Plaintiffs-Appellants,

v.

JOSEPHINE M. DRISCOLL, ACTING
INSURANCE COMMISSIONER of
THE STATE OF OREGON,
Defendants-Appellees.

LAWRENCE HELTON, DAVID HOYAL,
WADE LIGGETT, et al.,
Plaintiffs-Appellants,

v.

ROGUE VALLEY PHYSICIANS'
SERVICE, et al.,
Defendants-Appellees.

LAWRENCE HELTON, DAVID HOYAL,
et al.,
Plaintiffs-Appellants,

v.

GREATER OREGON HEALTH SERVICES,
Defendant-Appellee.

CA No. 81-3173
Oregon

ORDER

Before: KENNEDY, FARRIS and NORRIS, Circuit Judges.

The panel as constituted in the above case has voted to deny the petition for rehearing and to reject the suggestion for rehearing en banc.

The full court has been advised of the suggestion for an en banc hearing, and no judge of the court has requested a vote on it. Fed. R. App. P. 35(b).

The petition for rehearing is denied and the suggestion for rehearing en banc is rejected.

App. E

KLAMATH LAKE PHARMACEUTICAL ASSOCIATION, an Oregon Nonprofit Corporation, on behalf of its assignors, Plaintiff,

v.

KLAMATH MEDICAL SERVICE BUREAU, an Oregon Nonprofit Corporation, and Klamath Bureau Pharmacy, Inc., a now-dissolved Oregon Nonprofit Corporation, Defendants.

Civ. No. 78-868.

United States District Court, D. Oregon.

Feb. 27, 1981

OPINION

SOLOMON, District Judge:

INTRODUCTION

Plaintiff is the assignee of several pharmacies in the Klamath Falls area. In 1978, it filed this action against the Klamath Medical Service Bureau (KMSB), a nonprofit provider of health insurance and health care services, and Klamath Bureau Pharmacy, Inc. (KBPI), a nonprofit pharmacy.[1]

KMSB offers four health insurance policies. The first type

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1 KBPI was dissolved in 1976, and KMSB purchased its assets.

provides major medical coverage with basis benefits. The basic benefits provision includes a pharmacy benefit, which permits insureds to purchase prescription drugs from the KMSB pharmacy and pay only one or two dollars for the prescription. This contribution is called a "co-pay." The major medical provision of this policy covers the insured for 80 percent of all medical expenses, including prescription drugs, in excess of a $50.00 deductible. Under this provision, the insured is not limited to the KMSB pharmacy but may have prescriptions filled at any pharmacy.

The second policy includes major medical coverage, and a basic benefit package, without the pharmacy benefit. This policy is available only on a group basis. The third policy is the same as the second, and is available to individuals only. The fourth supplements medicare coverage and offers no coverage for prescription drugs.

Plaintiff attacks the prescription drug benefit of the first policy, in three separate causes of action. In the first, plaintiff contends that KMSB purchased prescription drugs at prices and terms not available to plaintiff's assignors, in violation of the Robinson Patman Act. In the second, it contends that KMSB has created an illegal tying arrangement by including a prescription drug benefit in its insurance coverage. In the third, it contends that the prescription drug benefit violates the Sherman and Clayton Acts because it restrains KMSB's insureds from

purchasing prescription drugs from plaintiff's assignors.

Defendants seek a partial summary judgment. They contend that the McCarran-Ferguson Act exempts any contract between KMSB and its insureds from the Clayton and Sherman Acts. They, therefore, assert that they are entitled to judgment on the second cause of action, and also on any of the violations charged in the third cause of action based on a contract between KMSB and its insureds.

McCARRAN-FERGUSON ACT

To qualify for an exemption under the McCarran-Ferguson Act, 15 U.S.C. § 1011 et seq., three conditions must be met. First, the anticompetitive practices must be part of the business of insurance, not merely the business of insurance companies.[2] Second, those practices must be

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2 15 U.S.C. § 1011:

> Congress declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.

regulated by the state.[3] Third, the anticompetitive practices must not take

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3 15 U.S.C. § 1012:

> (a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.
>
> (b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any state for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: Provided, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 14, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

the form of coercion, intimidation or boycott.[4]

1. Business of Insurance

Plaintiff contends that the prescription drug benefit included in one type of KMSB insurance policy is not the "business of insurance" under the McCarran-Ferguson Act. It cites Group Life and Health Insurance Co. v. Royal drug, 440 U.S. 205, 99 S.Ct. 1067, 59 L.Ed.2d (1979). In that case, Blue Shield offered health insurance policies which included a prescription drug benefit. Insureds with this coverage who purchased their prescriptions from a participating pharmacy paid only two dollars for the prescription, and the pharmacy recovered its cost of the prescription from Blue Shield. But an insured who purchased a prescription from a non-participating pharmacy paid the pharmacy the full price, and would then be reimbursed by Blue Shield for 75 percent of the full price less two dollars.

Any licensed pharmacy could be a participating pharmacy, but the participating pharmacies were required to accept a two dollar mark-up on each sale. Royal Drug contended that the

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4 15 U.S.C. § 1013(b):

> Nothing contained in this chapter shall render the said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation.

agreements between Blue Shield and the participating pharmacies violated the antitrust laws because they discouraged Blue Shield's insureds from using non-participating pharmacies. Blue Shield contended that the agreements were "the business of insurance" and were exempt from the antitrust laws under the McCarran-Ferguson Act.

The Supreme Court defined the "business of insurance" to include two critical elements: the spreading and underwriting of an insured's risk and a relationship between the insurer and the insured. Id. at 211 and 215-216, 99 S.Ct. at 1076-1077. The Court held that the provider agreements between Blue Shield and the participating pharmacies contained neither of these elements. First, it rejected Blue Shield's argument that the provider agreements were basic to the pharmacy benefits they offered their insureds, and held that the provider agreements "served[d] only to minimize the costs Blue Shield incurs in fulfilling its underwriting obligations." This differed from Blue Shield's obligation "under its insurance policies, which insure against the risk that policy holders will be unable to pay for prescription drugs." Id. at 213, 99 S.Ct. at 1074. Second, the agreements were not between an insurer and an insured. blue Shield was therefore not exempt under the McCarran-Ferguson Act.

Although this case, like Royal Drug, involves a pharmacy benefit, the two cases are distinguishable. In Royal Drug, plaintiffs challenged an agreement

between an insurer and drug providers, and the Court held that because these agreements did not directly spread or underwrite the insured's risk of needing prescription drugs, they were not the business of insurance. There, plaintiff challenges the pharmacy benefit in the insurance policy itself. The benefit, like other provisions in the insurance policy, spreads the risk that the insured may need the covered service among all those who pay premiums for that coverage. Royal Drug by its own terms does not extend to benefit provisions in the insurance policy itself. Id. at 213, 230 n. 37, 99 S.Ct. at 1074.

2. State Regulation

The second requirement of the McCarran-Gerguson Act is that the business of insurance be regulated by state law. 15 U.S.C. § 1012(b).

KMSB is regulated by the Oregon Insurance Code under ORS § 750.005-.340, the provisions which cover Health Care Contractors. These sections make applicable to KMSB many of the regulations to which the business of insurance generally is subject. Section 743.006 requires insurers to submit their policy forms to the Insurance Commissioner for approval. Section 743.009 requires the Insurance Commissioner to disapprove the policies if they do not comply with the law, are prejudicial to the insurer's policy holders, or are unjust, unfair, or inequitable. Subsection 746.160(3) forbids insurance company from "doing anything which is detrimental to free

competition in the business or injurious to the insuring public."

This regulatory scheme satisfies the second requirement of the McCarran-Ferguson Act. Dexter v. Life Assurance Society of the United States, 527 F.2d 233 (2nd Cir. 1975); Transnational Insurance Co. v. Rosenlund, 261 F.Supp. 12, 25-26 (D.Or. 1966).

Plaintiff contends that the McCarran-Ferguson Act does not apply because the Oregon Insurance Code does not specifically regulate the practice of pharmacy, or the particular practices in issue here. If the state regulates the business of insurance, and the practices challenged are part of the business of insurance, the failure of the state to react to a particular practice does not affect the application of the McCarran-Ferguson Act. Addrisi v. Equitable Life Assurance Society of the United States, 503 F.2d 725 (9th Cir. 1974), cert. denied, 420 U.S. 929, 95 S.Ct. 1129, 43 L.Ed.2d 400 (1975).

3. Boycott

Finally, plaintiff contends that KMSB's requirement that its insureds use the KMSB pharmacy to receive the pharmacy benefit amounts to a boycott, and is therefore subject to the antitrust laws under § 1013(b) of the McCarran-Ferguson Act. Specifically, plaintiff alleges that KMSB's pharmacy is in direct competition with plaintiff's assignors, and that KMSB has, with its co-conspirators,

attempted to boycott, coerce, or intimidate plaintiff's assignors.[5]

To meet the boycott exception, plaintiff must show that its assignors have been boycotted because they have been denied all access to KMSB insureds who purchase prescription drugs. In St. Paul Fire and Marine Insurance v. Barry, 438 U.S. 531, 98 S.Ct. 2923, 57 L.Ed.2d 943 (1978), the Court found a boycott in the sale of medical malpractice insurance, because the concerted activity "foreclosed all possibility of competition anywhere in the relevant market." Id. at 553, 98 S.Ct. at 1935.

KMSB does not preclude its insureds from patronizing plaintiff's assignors. First, those insureds who have the pharmacy benefit also have major medical coverage, and when they have satisfied the nominal deduction, are reimbursed for prescription drug expenses without regard to the pharmacy at which they purchased the prescription. An insured may elect to use either part of his insurance coverage in claiming pharmacy benefits. The major medical coverage may be more advantageous because of the "co-pay" requirement of the pharmacy benefit.

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5 Defendant's co-conspirators are identified as physicians affiliated with KMSB; public body signatories and employer signatories to KMSB contracts with prescription drug benefits; and labor unions that obtained KMSB contracts with prescription drug benefits for their members.

second, even if the subscriber elects to use the KMSB pharmacy benefit, the insured may use other pharmacies in an emergency or when the KMSB pharmacy is closed, without losing the benefit.

I hold that there was no coercion, intimidation, or boycott.

CONCLUSION

Defendants' motion for partial summary judgment is granted. Defendants are entitled to judgment on the second cause of action, and on the third cause of action for those violations which are based on a contract between KMSB and its insureds.

I leave to future proceedings plaintiff's Robinson Patman Act claims, and also plaintiff's claims based on a tying agreement between KMSB and KBPI.

App. F

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

KLAMATH-LAKE PHARMACEUTICAL ASSOCIATION, an Oregon non-profit corporation, on behalf of its assignors,
Plaintiff-Appellant,

vs.

KLAMATH MEDICAL SERVICE BUREAU, an Oregon non-profit corporation, and KLAMATH BUREAU PHARMACY, INC., a now dissolved Oregon profit corporation,
Defendants-Appellees.

Appeal from the United States District Court for the District of Oregon
Gus J. Solomon, District Judge, Presiding
Argued and Submitted August 4, 1982

No. 81-3608
CV 78-868-S0

OPINION

Before: KILKENNY, SNEED, and SKOPIL, Circuit Judges

SNEED, Circuit Judge:

This appeal was filed by Klamath-Lake Pharmaceutical Association (Association), the assignee of the antitrust claims of a group of pharmacies that service the Klamath Falls, Oregon area. Association's assignors have been losing business to a local nonprofit health care provider,

Klamath Medical Service Bureau (Provider), ever since it began to offer prescription drugs in kind under its group health insurance policies. Association in 1978 sued Provider and Klamath Bureau Pharmacy, Inc. (Pharmacy), a local for profit pharmacy Provider once used to distribute prescription drugs under its pharmacy benefit. The district court, after allowing Association to conduct extensive discovery, could not find any wrongdoing and dismissed the lawsuit in a series of partial summary judgments. For the reasons stated below, we affirm.

I.
STATEMENT OF FACTS

At the time Association brought this suit, Provider offered two different group policies.[1] Both had major medical coverage and a package of basic benefits, but only one included a pharmacy benefit. This supplemental benefit, available for a higher policy premium, entitled insureds to purchase prescription drugs for a small processing fee. The nominal "copay" amount was set at one or two dollars per prescription. Provider's success in marketing its pharmacy benefit led to this lawsuit.

Until July 1, 1976, Provider supplied pharmacy benefits exclusively through Pharmacy. Provider at one point considered expanding its distribution network. Its board of directors voted at their August, 1974, meeting to invite local pharmacies to participate if they would accept reimbursement for each prescription at pharmacy cost plus ten

percent, minus a copay amount of one dollar. The pharmacies' response, outlined in a letter from pharmacist Robert Gion, was to insist on receiving average wholesale cost plus $2.50 per prescription, minus the copay amount. This rate, which was modeled after Blue Cross' reimbursement policies, would have increased Provider's direct cost for most prescriptions. An expanded program would also have been more expensive to operate. Ted Dicken, Provider's executive director, estimated to the board of directors that increasing the number of participating pharmacies would result in a three percent increase in administrative costs. The board referred the question to its consumer advisory committee, which recommended that the program not be expanded on these terms. The board agreed, deciding, in Dicken's words, that "at this time it would not be feasible to open the K.M.S.B. Prescriptive drug benefit to other prescription outlets." The increase in premiums and in administrative complexity outweighed the benefit of any added convenience to subscribers.

In 1976 Provider decided to distribute drugs directly. It bought out Pharmacy, dissolved it, and set up a pharmacy on its own premises. Thus, as of July 1, 1976, insureds with few exceptions had to get their prescriptions filled by Provider if they used the pharmacy benefit.

Competing pharmacies were not entirely cut off from business with the insureds of Provider. Groups without the pharmacy benefit had no incentive to

shop at Pharmacy while it supplied drugs for Provider because it charged them full market rates. Furthermore, once Provider began to fill prescriptions, it limited sales to insureds using the pharmacy benefit. This restriction forced other policyholders, and all uninsured customers, to use the community pharmacies. In addition, the 10,000 policyholders without the pharmacy benefit were entitled to reimbursement under their major medical provision for 80% of their medical expenses, including prescription drugs, subject to a fifty or hundred dollar deductible. Their purchases constituted a substantial amount of business of the pharmacies. Even policyholders with the pharmacy benefit were free to patronize other pharmacies after hours or during holidays. Although these purchases were made at full cost, reimbursement of 100% of this cost less the copay amount was provided under the terms of the pharmacy benefit. This privilege was important because Provider's pharmacy was only open until 6:00 P.M. on weekdays and 3:00 P.M. on Saturday. Policyholders traveling outside of the Klamath falls area, and those living in outlying communities, could also use local pharmacies and be repaid under the terms of the pharmacy benefit.

Nonetheless, Provider's prescription drug program cut substantially into the business of local pharmacies. Provider's prescriptions more than doubled between 1974 and 1978, from 33,440 to 77,541; several local pharmacies went out of business and the sales of others dropped rapidly. In response seven pharmacies assigned their

antitrust claims to Association, which then brought this lawsuit.

II.
THE ISSUES ON APPEAL

Association alleged three causes of action in its complaint. First, it accused Pharmacy and Provider of receiving prescription drugs on terms unavailable to its members, in violation of the Robinson-Patman Act, 15 U.S.C. § 13(f). Second, it claimed that Pharmacy and Provider conspired with affiliated physicians, public and private signatories of the group contracts, and labor unions in an attempt to monopolize and restrain trade by compelling insureds to boycott Association's members, in violation of sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1-2. Third, it alleged that the insurance contracts tied the health care policy to the prescription drug benefit, in violation of section 3 of the Clayton Act, 15 U.S.C. § 14.

Provider and Pharmacy answered with the affirmative defense of exemption from the antitrust laws under the McCarran-Ferguson Act, 15 U.S.C. §§ 1011, 1015. Association sought summary judgment on this issue in March, 1979. The district court agreed to strike the defense as it affected the agreement between Provider and Pharmacy.[2]

In October, 1979 Provider filed for partial summary judgment asserting that the McCarran-Ferguson Act shielded it from both the charges of tying and those parts of the boycott claim that

rested on the health insurance contract between Provider and its insureds. The court agreed.

This left for resolution only the Robinson-Patman charge and the boycott claim as it applied to Provider's agreement with Pharmacy. Provider and Pharmacy moved for summary judgment on these remaining claims in August 1981. They sought, in the alternative, dismissal of the action under Fed. R. Civ. P. 17(a) because Association was not a real party in interest. They also argued that the assignments did not convey all of the assignors' claims. The district court granted the motion to dismiss. Because of the likelihood of appeal, it went on to reach the merits of the remaining issues. It held for the defendants on these as well. The Robinson-Patman claim fell because Association had turned up only one minor price variation among the thousands of invoices it reviewed during discovery. The court then summarily denied the residual boycott and tying claims.[3] Association appealed.

The issues that must be considered by this court are as follows. First is the validity of the assignments. If Association cannot act as assignee, this appeal must be dismissed. Next are the major substantive problems: the merits of the Robinson-Patman claim, the affirmative defense based on the McCarran-Ferguson Act to the tying and boycott claims, and the merits of these two claims. Last is Association's argument that the district court should have allowed it to amend or

supplement its claim. After considering briefly the use of summary judgment in antitrust cases, we will address these issues in order.

III.
SUMMARY JUDGMENT AS APPLIED TO ANTITRUST CASES

Summary judgment, dependent as it is on the absence of a "genuine issue as to any material fact," requires an assessment of evidence regarding issues of material fact in the light most favorable to the party opposing the motion to grant such judgment. ILGW v. Sureck, 681 F.2d 624, 628-29 (9th Cir. 1982); Heiniger v. City of Phoenix, 625 F.2d 842, 843 (9th Cir. 1980). Summary judgment traditionally has been used sparingly in antitrust litigation because of the factual intricacy of many antitrust issues. See Poller v. Columbia Broadcasting System, Inc., 368 U.S. 464, 473 (1962). At the same time, however, antitrust litigation, if made immune from summary judgment, could become an anticompetitive activity itself. For example, a losing competitor could employ an antitrust suit to harass its victorious opponent. So employed the antitrust laws would impose unwarranted economic costs on the marketplace. Thus, to keep these costs in check we should use summary dispositions to dispose of antitrust complaints that lack any significant supporting evidence. See, e.g., First National Bank v. Cities Service Co., 391 U.S. 253, 289-90 (1968); Betaseed, Inc. v. U & I, Inc., 681 F.2d 1203, 1207-08 (9th Cir. 1982). Our analysis

in this case is guided by these principles.

IV.
THE VALIDITY OF THE ASSIGNMENT TO ASSOCIATION

The district court found that Association was not a real party in interest as required by Rule 17(a), but was merely a nominal party which should not have been allowed to prosecute this action. It reached this result because, in its view, the assignors "retained their interest in the outcome of the litigation." Association's request for treble damages for the assignors was taken as an indication that no true transfer of claims had occured.

The district court erred. An assignment of claims does not prevent the assignors from receiving the benefits of the litigation. Pacific Coast Agricultural Export Association v. Sunkist Growers, Inc., 526 F.2d 1196 (9th Cir. 1975), cert. denied, 425 U.S. 959 (1976). Thus, in Sunkist Growers we upheld an award of damages to fresh fruit growers in litigation brought on assignment by their trade association. See id. at 1200. The consideration that moved to Association in this case consists of the transfer to it of authority to bring the suit and to allocate the proceeds. In exchange Association undertook to bring this lawsuit. It is not necessary that the assignors forfeit all interest in possible damages before consolidating their claims in a more efficient class suit.[4] Rule 17(a) is designed to ensure that lawsuits are brought in the

name of the party possessing the substantive right at issue. See 6 C. Wright & A. Miller, Federal Practice and Procedure § 1541, at 635-36 (1971 & Supp. 1982). It is not to prevent a consolidation of individual claims such as occurred here.

The district court also found the transfer of Clayton and Robinson-Patman Act claims ineffective because of a lack of specificity in the assignment. Whether this is correct presents a question of law reviewable de novo by this court. Maykuth v. Adolph Coors Co., No. 81-3152, slip op. at 4848 (9th Cir. Oct. 19, 1982); Martin v. United States, 649 F.2d 701, 703 (9th Cir. 1981); Kittitas Reclamation District v. Sunnyside Valley Irrigation District, 626 F.2d 95, 98 (9th Cir. 1980), cert. denied, 449 U.S. 1079 (1981). Because there are no disputed factual circumstances, this issue is also ripe for summary disposition.

We again find that the district court erred. Our task is to enforce the intent of the parties. Sunkist Growers, 526 F.2d at 1208. Each assignment contained three descriptions of the claims transferred. An initial paragraph described the transfer as covering all claims arising "by reason of any violation of the Sherman Antitrust Act, as amended, 15 U.S.C. § 1, et seq." Association for its part promised to seek relief "under the federal antitrust laws." The paragraph following this phrase then waived the assignors' rights "under the antitrust laws to proceed as an individual named plaintiff." The district court held

that the first description should be given controlling weight and be read to limit the assignment to Sherman Act claims, leaving the pharmacies free to relitigate claims under the Clayton and Robinson-Patman Acts.

We do not find this a plausible interpretation. The contract must be read as a whole. The common-sense meaning of the transfer under the Sherman Act, "as amended," when read in conjunction with Association's broad promise to pursue relief "under the federal antitrust laws" and the assignors' equally broad waiver of their rights to proceed "under the antitrust laws," is that it conveys all antitrust claims against Provider and Pharmacy. This is what the parties to the assignment intended. Provider has not suggested any reason for them to have intended otherwise. Association's assignors, whose interests do not diverge, understandably sought to secure more vigorous prosecution of a common opponent, and to increase the likelihood of recovery for related injuries. The added expense of separate actions on non-Sherman Act claims makes Provider's theory of reservation for later prosecution implausible. Furthermore, had the assignors sought to save their claims for later use, they would not have employed the language in question. The assignments are not exemplars suitable to guide future litigants; they are, however, adequate to effectuate a full assignment of all claims. We therefore proceed to Association's substantive claims.

V.
PRICE DISCRIMINATION IN PROVIDER'S PURCHASE OF DRUGS FROM LEDERLE

The district court found no merit in Association's complaint of price discrimination. Provider produced over 7,000 documents that covered its purchases from 1974 until mid-1979. Among these Association turned up only one instance of alleged discrimination. Provider purchased drugs from Lederle Laboratories on a ten percent volume discount during 1978 and early 1979. The discount was available to any buyer with purchases over $300. Although its members did not remember having received the offer, Association presented no other evidence of unavailability. This is not enough.

The district court was correct in holding that there was no violation. Any difference in the prices of similar goods is, of course, price discrimination. FTC v. Anheuser-Busch, Inc., 363 U.S. 536, 549-51 (1960); William Inglis & Sons Baking Co. v. ITT Continental Baking Co., 668 F.2d 1014, 1040 (9th Cir. 1981), cert. denied, 103 S.Ct. 57 (1982). The discrimination, however, must be illegal. A buyer who receives a price differential cannot be liable under the Robinson-Patman Act unless the seller is in violation of the Act as well. Great Atlantic & Pacific Tea Co. v. FTC, 440 U.S. 69, 75-78 (1979). Association did not prove any violation by Lederle. It offered no proof that Lederle's discount injured competition substantially. It therefore failed to make the showing required of it. See Inglis, 668 F.2d at 1039-40;

Janich Brothers v. American Distilling Co., 570 F.2d 848, 854-55 (9th Cir. 1977), cert. denied, 439 U.S. 829 (1978); Texas Gulf Sulphur Co. v. J.R. Simplot Co., 418 F.2d 793, 806-07 (9th Cir. 1969).

Nor did Association attempt to show that Provider knowingly induced or received Lederle's discriminatory offer. 15 U.S.C. § 13(f); Automatic Canteen Co. v. FTC, 346 U.S. 61 (1953); J.R. Simplot, 418 F.2d at 803-06. Construing the evidence in the light most favorable to Association, we hold that there was no Robinson-Patman violation.

Association argues that it should have been allowed additional discovery that would enable it to examine Provider's records for recent years. Provider produced documentation for its purchases through mid-1979. Some two years elapsed before the district court issued its final opinion in October 1981. In September 1981 Association filed a request to extend discovery to cover this period, complaining that "since mid-1979 Provider has engaged in a major expansion of its activities, and said expansion is highly relevant to the . . . issues raised by the pending summary judgment motion."

The district court denied the request. In doing so it acted well within its discretion. Association does not indicate what it might expect to discover. At some point, the possibility that additional investigation might turn up a real lead becomes less important

than the injustice to a defendant against whom no significant evidence has been produced. We have reached that point in this case. The district court did not abuse its discretion. See Portland Retail Druggists Association (PRDA) v. Kaiser Foundation Health Plan, 662 F.2d 641, 646 (9th Cir. 1981); Program Engineering, Inc. v. Triangle Publications, Inc., 634 F.2d 1188, 1193 (9th Cir. 1980).

VI.
THE TYING CLAIM

A. As Between The Basic Health Care Contract and the Pharmacy Benefit

We now turn to Association's allegation of tying. Association alleged a tie between "the basic prepaid health care contract, and the optional prescription drug benefit that can be obtained only if the subscriber has the basic plan." The district court rejected Association's argument because it found that both the basic health care contract and the optional drug benefit contract came within the McCarran-Ferguson exemption. We agree.

1. The business of insurance

The antitrust exemption for the "business of insurance" arose in response to the Supreme Court's decision in United States v. South-Eastern Underwriters Association, 322 U.S. 533 (1944), which overruled prior holdings placing insurance outside the reach of the commerce clause. Congress, wishing to protect the states' traditional role

in the regulation of insurance and to avoid endangering the cooperative ratemaking that had played a major role in the industry's development, see Group Life & Health Insurance Co. v. Royal Drug Co., 440 U.S. 205, 217-24 (1979), quickly passed the McCarran-Ferguson Act. The Act removed the "business of insurance" from antitrust enforcement if (1) it was subject to state regulation and (2) did not amount to a boycott under the Sherman Act.[5]

The Supreme Court in Royal Drug excluded health insurers' agreements with third party providers from the business of insurance. Blue Shield, the defendant in Royal Drug, invoked the insurance exemption when a group of pharmacists challenged the administration of the pharmacy benefit in Blue Shield's health insurance policy. Blue Shield's benefit, although similar to Provider's in many respects, did not supply drugs directly to its insureds. Independent pharmacies could participate in the plan provided they accepted Blue Shield's reimbursement schedule. Most pharmacies chose to participate and signed a provider agreement with Blue Shield.[6]

The question before the Supreme Court was whether the exemption covered the agreements with third party providers. The Court held that it did not; provider agreements between health care insurers and participating pharmacies were not part of the business of insurance. Such agreements were subject to normal antitrust scrutiny.

The "underwriting or spreading of risk" was held to be an "indispensable characteristic of insurance." Id. at 212. Cost-cutting efforts pursued through such arrangements as provider agreements, however, were no different than the acts of "any enterprise with the responsibility to minimize costs and maximize profits." Id. at 217. Such business activities affected only the method of payment--not the spreading of risk. The provider agreements were further distinguishable from the business of insurance because they were not part of the contract between the insurer and its insureds, and because they involved the insurer's relationship with entities outside of the insurance industry. Id. at 215-17, 231-32.

The Court applied Royal Drug in Union Labor Life Insurance Co. v. Pireno, 102 S.Ct. 3002 (1982). Pireno, a New York chiropractor, challenged an insurer's practice of conditioning reimbursement of unusually high chiropractic fees on the decisions of a peer review committee staffed by the New York State Chiropractic Association.[7] The Court tested the referral policy under three requirements drawn from Royal Drug: (1) whether the practice transferred or spread a policyholder's risk; (2) whether it lay at the heart of the relationship between insurer and insured; and (3) whether it was limited to entities within the insurance industry. Id. at 3009. It held that the referral practice did not transfer risk; it merely reduced costs. The insurance policy transferred risk and was the indispensable component of

insurance. Although the policy defined the burden transferred as the cost of "necessary" treatments and "reasonable" charges, standards apparently applied in practice by the chiropractors' committee, this did not make the committee's involvement the business of insurance. This involvement was "logically and temporally unconnected to the transfer of risk accomplished by ULL's insurance policies." Id.[8]

The Court also held that the insurer's relationship with the peer review committee failed Royal Drug's second and third requirements. The peer review arrangement was beyond the primary relationship between insurer and insured. Id. at 3009-10. Finally the peer review board was not an "entity" in the insurance industry. Its assistance in regulating fees was but cost-cutting activity. Id. at 3010-11.

2. The business of insurance exemption and tying between the basic health care contract and the pharmacy benefit

Association's tying claim, as already noted, strikes at the health care contract and the pharmacy benefit appended to it. Royal Drug requires that we consider the possibility that the health insurance contract here involved, even when shorn of a pharmacy benefit contract, does not fit the exemption. 440 U.S. at 225-30 & n.37. We have thus far skirted the issue in other situations. See Hahn v. Oregon Physicians Service, 689 F.2d 840, 843 n.2 (9th Cir. 1982); Portland Retail Druggists Association v. Kaiser

Foundation Health Plan, 662 F.2d 641, 647 (9th Cir. 1981); see also St. Bernard Hospital v. Hospital Service Association, 618 F.2d 1140, 1144-45 & nn. 3-5 (5th Cir. 1980). We cannot do this here because Provider argues that the exemption attached to its health insurance policy and also shielded the alleged tying agreement.

We hold that it does. Our decision turns on the Court's reasoning in Royal Drug. The insurer-insured agreement embodied in the basic health care contract and its supplemental pharmacy benefit settles the distribution of the risk that insureds will need medical goods and services, including prescription drugs. It defines the relationship between insurer and insured; and it is limited to these two traditional actors in the insurance industry.

The Court in Royal Drug did observe that health insurance was not a common form of insurance in 1945, the year Congress passed the McCarran-Ferguson Act. 440 U.S. at 225-30.[9] It did not, however, exclude the business of health insurance from the exemption. All it said was "[t]his is not to say that the contracts offered by Blue Shield to its policyholders, as distinguished from its provider agreements with participating pharamacies, may not be the 'business of insurance' within the meaning of the Act." Id. at 230 n.37.

We do not believe that the Court intended to remove the business of

health insurance from the McCarran-Ferguson exemption. Had it so intended its detailed analysis of the limits of the insurance exemption in Royal Drug would have been unnecessary. Nor does Pireno suggest otherwise. There both the majority and the dissenters discussed the health care policies without once suggesting that the business of health insurance was not included in the business of insurance. Although the insurer was a traditional insurer, not, as in this case, a health care provider, this should not be determinative. It is the business of insurance, not merely the business of traditional insurers, that activates the exemption. See Royal Drug, id. at 217, quoted in Pireno, 102 S. Ct. at 3008, 3010.

Isolation of risk distribution as the primary characteristic of the business of insurance also weighs against limiting that business to risks being shifted by traditional insurers in 1945. It is the actuarial uncertainty inherent in projecting risks and the insurance industry's corresponding need for cooperation that makes its exemption from the antitrust laws appropriate. See Royal Drug, 440 U.S. at 221-22. Health insurance also has these charactertistics. The business of insurance, within the meaning of the McCarran-Ferguson exemption, should not be closed to policies that shift risks not ordinarily so shifted in 1945. Thus, Provider's policies with its insureds, insofar as they shift the risks of medical costs, including pharmacy costs, fully qualify as the business of insurance.

3. The state regulation requirement

Having settled that Provider's policies, insofar as they shift the risks of medical and pharmacy costs, partake of the business of insurance, we must next determine whether these policies were subject to state regulation. 15 U.S.C. § 1012(b). We hold that they were. Oregon unquestionably regulated health insurance policies. Specific regulations for health care service contractors were included in the Insurance Code, Or. Rev. Stat. §§ 750.005-340 (1981), as were guidelines for group health insurance, id. §§ 743.522-558. More generally, the State authorized the Insurance Commissioner to issue regulations banning "any unfair or deceptive act or practice," id. § 746.240, and directed insurers to refrain from "anything which is detrimental to free competition in the business or injurious to the insuring public," id. § 746.160(3). It specifically prohibited abuses like rate control, id. 764.160(1), and those tying pratices that it found undesirable, see id. § 746.130 (prohibiting insurers from tying sale of property or services to insurance without a separate charge); id. § 746.191 (prohibiting tying of insurance to sale of property or real estate). Furthermore, insurers were subject to state antitrust regulation to the extent free of state insurance regulation. id. § 646.740(4).

This meets the McCarran-Ferguson requirement that the state regulate the challenged activity. See Addrisi v Equitable Life Assurance Society of the United States, 503 F.2d

725, 727-28 (9th Cir. 1974), cert. denied, 420 U.S. 929 (1975).[10]

4. The boycott exclusion

The shelter of the exemption does not extend to practices amounting to a boycott under 15 U.S.C. § 1013(b). This requirement, however, does not stand in the way of an exemption for Provider's policy. The definition of a boycott for purposes of the McCarran-Ferguson exemption is set forth in St. Paul Fire & Marine Insurance Co. v. Barry, 438 U.S. 531 (1978). St. Paul rejected prior definitions that restricted the scope of the term to boycotts among insurers and agents, see, e.g., Addrisi, 503 F.2d at 728-29. The Court held that the boycott exception should take its broad Sherman Act meaning. Thus, boycotts were not merely limited "to concerted activity against insurance companies or agents or, more generally, against competitors of members of the boycotting group," but extended to refusals to deal with customers of some or all of those engaged in the boycott. 438 U.S. at 552.

To foreclose an exemption for Provider's health insurance policies, however, Association had to prove that the policies constituted an "agreement to boycott, coerce, or intimidate." This it has not done. Association asserts that the conspirators induced policy-holders to boycott the local pharmacies by the "effective economic compulsion" derived from its pharmacy benefits. It is true that Provider provided an effective economic

inducement for customers to buy drugs from it. And it is undisputed that policyholders who had chosen the pharmacy benefit had to patronize Pharmacy and, later, Provider's on-premises pharmacy to use the benefit.[11] Reimbursement for after-hours and emergency prescriptions purchased elsewhere probably did little to diminish the appeal of Provider's pharmacy benefit. But this does not establish that the health insurance policies implemented a boycott. Insureds remained free to purchase drugs from Association's members if they chose to do so. Provider offered to the public an attractive package which sold well to the detriment of Association's members. The package is part of the many changes affecting the delivery of health care in our time. We are not prepared to hold that the package should be banned from the marketplace by the antitrust laws. Only such a holding would yield the result the plaintiff seeks.

Such a holding would be particularly inappropriate in this case. Provider not only did not exclude Association's members from competing for its policyholders; it also gave them a chance to join the business. Their response was to offer to participate only under terms more favorable to them. When this was rejected they chose to sell less at a higher price rather than more at a lower price. They were entitled to make this choice. They are not entitled to employ the antitrust law to obtain the market position that will entitle them to both greater sales and higher prices.

Thus, we agree with the district court that the health care policy between Provider and its insureds constituted part of the business of insurance; that Provider was regulated by the State of Oregon; and that its pharmacy benefit did not embody a boycott of Association's members. The tying claim, resting as it does on the agreements embodied in the policy, accordingly must fail.[12]

B. As Between the Pharmacy Benefit And The Restrictions On The Sources From Which Drugs Can Be Purchased

Association had two tying theories. The first, as already demonstrated, alleged a tie between Provider's standard health policy and the pharmacy benefit addition. The second is more nebulous. The Association's initial complaint read as follows:

> A Provider subscriber desiring a prescriptive drug benefit was and is compelled to purchase the benefit as part of a Provider health care policy that "ties" said benefit to purchase of prescription drugs under the policy to a Provider-designated pharmacy and forbids the subscriber, at the risk of losing the benefit, from obtaining prescription drugs under the policy from any competitor of a Provider-designated pharmacy.

The district court took the mention of the designated pharmacy to raise, in addition to the tie in the insurance policy, a tie based on Provider's agreement with Pharmacy. The

court summarily rejected the claim.[13] We agree. The provider arrangement did not tie purchase of one product to purchase of another.

However, Association may also seek to allege a tie between the pharmacy benefit and its restrictions on the sources from which drugs may be purchased. As Association stated in its Amended Motion for Partial Summary Judgment, "The two products are an insurance benefit covering prescription drugs and the form in which that benefit is to be provided."

Interpreting Association's claim to rest on a tie between the pharmacy benefit and the drug purchase restrictions does not change the outcome. This "tying agreement," linking the pharmacy benefit set forth in the policy and the requirement that drugs be purchased from Provider or Pharmacy, fails for the fundamental reason that it does not implicate two different products.

To prevail on a tying claim, whether under section 1 of the Sherman Act, 15 U.S.C. § 1, or section 3 of the Clayton Act, 15 U.S.C. § 14, a plaintiff must first identify a tie between separate products. Hirsh v. Martindale-Hubell, Inc., 674 F.2d 1343, 1346-47 (9th Cir.), cert. denied, 103 S.Ct. 305 (1982); Hamro v. Shell Oil Co., 674 F.2d 784, 787 (9th Cir. 1982); Krehl v. Baskin-Robbins Ice Cream Co., 664 F.2d 1348, 1352 (9th Cir. 1982). Separateness is determined in part by whether the products are normally sold or used as a unit, and whether their

joint sale effects savings beyond those of combined marketing. Siegel v. Chicken Delight, Inc., 448 F.2d 43, 48 (9th Cir. 1971), cert. denied, 405 U.S. 955 (1972) (describing the "function of the aggregate" test). The critical factor is the extent to which a producer's offerings are in response to independently structured consumer demand. Products that function together and are sold in combination may still be "separate" if consumers would prefer to buy them individually at the price necessary to market them separately. Tying denotes illegal coercion: "Rules governing tying arrangements are designed to strike, not at the mere coupling of physically separable objects, but rather at the use of a dominant desired product to compel the purchase of a second, distinct commodity." Id. at 47 (citing Times-Picayune Publishing Co. v. United States, 345 U.S. 594, 614 (1953)).[14] Whether a producer's combined products should be considered as separate can be decided only by looking at consumer behavior. It is the relationship of the producer's selling decision to market demand, not the physical characteristics of the products alone, that determines the existence of legally separable products.

There was no separation between the pharmacy benefit and the restrictions on the sources from which drugs can be purchased on these principles. Insureds, the consumers, certainly did not consider these as two separate products. In deciding whether to buy the pharmacy benefit, they made just one decision, comparing the expected cost of

the benefit plus copayments for drug purchases against the expected cost of drugs bought at the independent pharmacies. The risk insureds sought to transfer was the risk of high pharmacy bills. The product these consumers sought was a means by which they could satisfy their drug needs on favorable terms. Their purchase of drugs in the required manner was the consummation of the pharmacy benefit, not an unwanted and unnecessary product tied to the desired product.

To treat the pharmacy benefit as separate from the drug purchase provisions makes no more sense than treating a contract granting an option with respect to an item as a product distinct from that consisting of the terms on which the option is to be exercised. The entire option is one product.

This conclusion is not at odds with the Supreme Court's functional division of Provider's role into risk distribution and cost reduction. Provider performed both functions with one product. It differs not from an offer to perform garden maintenance. To maintain a garden requires many tasks of a different nature. The offer, however, is of a single product.

Nor does the split payment for the benefit, requiring an initial premium and then a copayment with each purchase, indicate two products. Copayment's purpose, whatever it might be, does not split the drug purchase terms of the pharmacy benefit from the pharmacy benefit itself. It functions

no differently than would a provision in the offer to perform garden maintenance that required the owner of the garden to supply the fertilizer.

No doubt some insureds would have preferred to receive cash from Provider and then to buy their drugs from Association's members had their prices been comparable to those available under the pharmacy benefit. This appears not to have been the case. This contingent preference does not demonstrate the existence of two products. It merely shows that Provider's pharmacy benefit product would have been less appealing had the Association members' prices been lower.

In conclusion, we find no support for a second tying claim. As we stated in Hirsh, "rules governing tying arrangements are designed to strike solely at practices employed to impede competition on the merits." 674 F.2d at 1348. Provider did not impede, but rather stimulated, competition within the pharmaceutical market. We therefore proceed to Association's remaining charge.

VII.
THE ALLEGED BOYCOTT TO EXCLUDE ASSOCIATION'S MEMBERS FROM PROVIDER'S BUSINESS

The most favorable interpretation of Association's boycott complaint yields charges of a refusal to deal, an attempt to monopolize, and an exclusive purchasing agreement. The district court, in its amended opinion, dismissed part of this cause of action--the part

that rested on Provider's contract with its insureds--under the McCarran-Ferguson Act. We have already affirmed the exemption for Provider's health insurance policies. The court later granted summary judgment against Association on the merits of the residual claims (based on Provider's contract with Pharmacy).[15] We address these next.

We find no evidence, even interpreting the record most favorably toward Association, that requires that we reverse the district court's grant of summary judgment to Provider on the merits of the boycott claim. Association treated the health insurance contract as the end product of a wide group of conspirators that included Provider, Pharmacy, affiliated physicians, public body signatories, employer signatories, and labor unions. It alleged that these conspirators, by establishing the pharmacy benefit while refusing to deal with Association's members, sought to drive independent pharmacies from the market.

Association has done little, however, to support its charges. Some evidence of concerted activity directed at the alleged victims of the boycott must be offered for the case to survive summary judgment. The failure to meet this requirement enables us to dispose of Association's claims of a conspiracy between Provider and Pharmacy, on the one hand, and various physicians, public and private signatories of the health plan, and labor unions on the other. Association has not pursued its charges against any of the latter group.

Although conspiracy sufficient to survive summary judgment may be inferred from circumstantial evidence, the plaintiff must come forward with "significant probative evidence" that supports its conclusion. Ron Tonkin Gran Turismo, Inc. v. Fiat Distributors, Inc., 637 F.2d 1376, 1386 n.9 (9th Cir.), cert. denied, 454 U.S. 831 (1981); Blair Foods, Inc. v. Ranchers Cotton Oil, 610 F.2d 665, 672 (9th Cir. 1980).

The possibility of a conspiracy between Provider and Pharmacy is no better supported. Whether Pharmacy be viewed as the sole distributor of Provider's products, administering a package of benefits created by the health care provider, or as a supplier of products under contract to Provider, the arrangement constitutes a lawful scheme of vertical distribution. In the aftermath of Continental T.V., Inc. v. GTE Sylvania, Inc., 433 U.S. 36 (1977), we have established narrow grounds for imputing per se illegality to such restrictions: they must "always or almost always tend to restrict competition and decrease output [and not] 'increase economic efficiency and render markets more, rather than less, competitive.'" Krehl v. Baskin-Robbins Ice Cream Co., 664 F.2d 1348, 1356 (9th Cir. 1982) (quoting Broadcast Music, Inc. v. CBS, 441 U.S. 1, 19-20 (1980)); see, e.g., A.H. Cox & Co. v. Star Machinery Co., 653 F.2d 1302, 1305 & nn.3 & 5 (9th Cir. 1981); Ron Tonkin, 637 F.2d at 1381-82, 1385-88. There is no indication that the arrangement between Provider and Pharmacy would "always" have--or has ever had--the proscribed effect. Therefore, it does

not constitute a per se violation of the Sherman Act.

Association fares no better under rule of reason analysis. Its burden below was to uncover either anti-competitive intent or specific anticompetitive effects. A.H. Cox, 653 F.2d at 1306. It demonstrated neither. Provider's purpose in structuring the provision of drugs for its policyholders was to meet the terms of its policy at the least cost. Association has not shown that Provider or Pharmacy sought to injure competition in the pharmaceutical market. Provider even considered having Association's members join it; but they showed no interest in handling Provider's business at its prices.

There is also no evidence of injury to competition. Association complains of its members' business losses, but economic injury to competitors is not a per se violation of the antitrust laws. It is injury to the market, not to individual firms, that is significant. See A.H. Cox, 653 F.2d at 1307; Ron Tonkin, 637 F.2d at 1388; Kaplan v. Burroughs Corp., 611 F.2d 286, 291 (9th Cir. 1979), cert. denied, 447 U.S. 924 (1980). A plaintiff must show that the defendant intended to or did reduce the ability of others to compete before it becomes an actionable restraint of trade. See Knutson v. Daily Review, Inc., 548 F.2d 795, 803 (9th Cir. 1976), cert. denied, 433 U.S. 910 (1977). In an openly competitive market the inefficient fail; in a non-competitive system the efficient are precluded from competing. We cannot say

that Association's members have demonstrated that they are the efficient barred from competing rather than the inefficient who have failed. To hold otherwise would require that the Provider-Pharmacy arrangement be treated as illegal per se. This we cannot do. Provider's arrangement with Pharmacy was simply an exercise of its freedom to contract with whomever it chose in order to sustain itself in the marketplace. The general freedom of a single business to select its partners has been an established part of antitrust law since United States v. Colgate & Co., 250 U.S. 300 (1919).[16]

Neither of the other two charges that emerges from a liberal reading of Association's boycott complaint has any validity. There is insufficient evidence of either intent or predatory conduct to support an attempted monopolization claim. See Moore v. Jas. H. Matthews & Co., 550 F.2d 1207, 1219 (9th Cir. 1977); see generally William Inglis & Sons Baking Co. v. ITT Continental Baking Co., 668 F.2d 1014, 1027-39 (9th Cir. 1981). As Association has not proven this charge, we need not decide whether an attempted monopolization claim resting solely on Provider's direct provision of drugs would qualify for McCarran-Ferguson exemption. Finally, as already indicated, we reject Association's argument that Provider's agreement to supply discount drugs to subscribers who would patronize its pharmacy was an illegal purchasing agreement. See pp. 19-20 [66-67]. There is no merit to any of the boycott claims.

VIII.
ASSOCIATION'S PROCEDURAL MOTIONS

Association seeks to sustain the flickering life of this lawsuit by attacking the district court's denial of its motions to amend and to supplement its complaint. The trial court did not abuse its discretion by denying these motions.

Motions to amend, we recognize, are commonly granted. Although within the trial court's discretion, leave to amend "shall be freely given when justice so requires." Fed. R. Civ. P. 15(a); see Foman v. Davis, 371 U.S. 178, 182 (1962); McCartin v. Norton, 674 F.2d 1317, 1320 (9th Cir. 1982); United States v. Webb, 655 F.2d 977, 979 (9th Cir. 1981; Howey v. United States, 481 F.2d 1187, 1190 (9th Cir. 1973). We are required to review the exercise of the trial court's discretion to deny a motion to amend strictly. Thus, where the record does not clearly dictate the district court's denial, we have been unwilling to affirm absent written findings, Webb, 655 F.2d at 980, and have reversed findings that were merely conclusory, Howey, 481 F.2d at 1190-91.

At the same time, futile amendments should not be permitted. Foman, 371 U.S. at 182; Smith v. Commanding Officer, Air Force Accounting, 555 F.2d 234, 235 (9th Cir. 1977). In this case, it is clear that Association's motion should be denied for this reason. The district court rejected the motion because it was untimely, and for "other reasons." The

most important "other reason" was futility. Asked the purpose of amendment, Association's attorney could only answer vaguely that it would "bring damages up to the current" and "clarify the point" that Pharmacy was a forprofit institution. Association has not used Pharmacy's profit status to support any of its claims. And it does not have compensable damages unless it proves its case. It is clear that the district court believed that amendment on these lines could not affect the outcome of this lawsuit. We agree. We find no reason to overturn its decision.

The judgment of the district court is affirmed.

AFFIRMED.

FOOTNOTES

1. Provider's other two policies, one an individual policy and the other a group Medicare supplement, are not at issue in this lawsuit.

2. This motion was granted on stipulation, with Pharmacy and Provider free to renew the defense for the provider agreement if the Ninth Circuit later found a claim of exemption available in the aftermath of Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205 (1979). Such a defense has not become available. See Portland Retail Druggists Ass'n v. Kaiser Found. Health Plan, 662 F.2d 641, 647 (9th Cir. 1981).

3. As we read the district court's earlier amended opinion, it had in fact

already disposed of the tying claim in full. The meaning of its amended opinion is discussed in notes 13 & 15 infra.

4. The cases cited by Provider to challenge the assignment involve defects in the party bringing suit that are not present in this case. In Archie v. Shell Oil Co., 110 F. Supp. 542 (E.D. La. 1953), aff'd per curiam, 210 F.2d 653 (5th Cir.), cert. denied, 348 U.S. 843 (1954), the nominal plaintiff was an unpaid yardboy for an attorney who had given him a subsequently invalidated interest in real property via a third party. The district court dismissed the "strange document," which gave the nominal plaintiff the third party's power of attorney over the interest in land and, as consideration, conveyed the interest itself, as void under Louisiana law. Id. at 544. California League of Indep. Ins. Producers v. Aetna Casualty & Sur. Co., 175 F. Supp. 857 (N.D. Cal. 1959), did note in dictum that a suit brought by an association of insurance agents would have to be dismissed if the association were a "mere agent for collection," but it added that the association could maintain the suit as an "assignee for collection." Id. at 861. District Distribs., Inc. v. Heublein, Inc., 1971 Trade Cases (CCH) ¶ 73,695, at 90,901 (D.D.C. 1971), involved an ultra vires assignment that was also void for lack of consideration and champerty. In Cordova v. Bache & Co., 1971 Trade Cases (CCH ¶ 73,406, at 89,651 (S.D.N.Y. 1970), the president of an association of employees in the securities industry was denied standing to maintain an action in his own name

without an assignment from the employees. In the absence of similar defects, there is no need to prevent Association from bringing this lawsuit. The rule that an assignor can prosecute its case even if it must later account to the assignees for the proceeds is a seasoned part of Oregon law. See Hibernia Sec. Co. v. United Mfg. Co., 59 P.2d 384, 154 Or. 369, 379 (1936).

5. Section 2(b), 15 U.S.C. § 1012(b), provides in part that "[n]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance." Section 3(b), 15 U.S.C. § 1013(b), adds the qualification that "[n]othing contained in this chapter shall render the said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation."

6. Both nonparticipating and participating pharmacies brought the antitrust suit against Blue Shield. The headnotes to the Supreme Court opinion and that of the Fifth Circuit identify the plaintiffs as nonparticipating pharmacists. 440 U.S. at 205; 556 F.2d at 1375. In fact, half of the eighteen plaintiffs participated in Blue Shield's program, see Royal Drug Co. v. Group Life & Health Ins. Co., 415 F. Supp. 343, 347 (W.D. Tex. 1976), rev'd, 556 F.2d 1375 (5th Cir. 1977), aff'd, 440 U.S. 205 (1979). Their role in the case may have resulted more from a

desire to hedge their bets than to correct an antitrust violation.

7. The insurer, Union Labor Life Insurance Company (ULL), would reimburse only charges it decided were reasonable and necessary, a determination in which it deferred to the committee. Pireno had once sought review of his fees voluntarily, because he believed that going directly to peer review would permit him to avoid a cumbersome substantiation process. Pireno v. New York State Chiropractic Ass'n, 650 F.2d 387, 389 n.2 (2nd Cir. 1981), aff'd sub nom. Union Labor Life Insurance Co. v. Pireno, 102 S. Ct. 3002 (1982). His enthusiasm for the process waned when ULL began submitting his claims independently and the committee began rejecting them. Id.

8. The Court left the contours of its distinction unclear. It explained that the decision to honor a claim rested "entirely" with ULL. Pireno, 102 S. Ct. at 3010. Under this analysis, the peer review committee was only an "aid" in making this decision. It did not affect the policyholder directly because his only concern was "whether the claim is paid, not why it is paid." Id. (emphasis in original). But if Pireno was correct that ULL always followed the committee's decisions--an allegation the Court was to weigh most favorably to Pireno when considering ULL's motion for summary judgment--then ULL's decision "whether" to pay chiropractors would turn exclusively on the review board's actions. The questions "whether" and "why" a claim was paid would both rest with the chiropractors' association.

Compare id. at 3011 n.8 (peer review merely ancillary to claims adjustment because non-binding, even when ULL acted on committee's advice).

9. The Court's attempt to demonstrate that the McCarran-Ferguson Congress did not consider health service plans insurance policies drew a detailed response from the four dissenters. 440 U.S. at 233 (Brennan, J., joined by Burger, C. J., and Marshall & Powell, JJ.).

10. Unless the practice amounts to a boycott, the states are free to regulate it or choose not to regulate. They do not have to expressly authorize a specific activity, or proscribe it, for the exemption to apply. Addrisi, 503 F.2d at 728. It is enough that a detailed overall scheme of regulation exists. Id.; see, e.g., Freier v. New York Life Insurance Co., 679 F.2d 780, 782 (9th Cir. 1982). Our opinion in United States v. Crocker Nat'l Corp., 656 F.2d 428 (9th Cir. 1981), cert. granted sub nom BankAmerica Corp. v. United States, 102 S. Ct. 2294 (1982), did not narrow this requirement. Crocker indicated only that regulation of interlocking directorates among insurance companies would not be construed to protect interlocking directorates between insurance companies and banks. We did not state that the "most obvious reason for rejecting a claim of immunity is the absence of any state law regulating the challenged activity." Id. at 452. It is wrong to read this, as did the Court of Appeals for the District of Columbia in Proctor v. State Farm Mut. Auto. Ins. Co.,

675 F.2d 308, 317 n.17 (D.C. Cir.), cert. denied, 103 S.Ct. 86 (1982), to require that a regulation specifically affect the challenged practice for it to be exempt. Crocker only applies in the absence of any general scheme of regulation governing insurers' corporate interlocks with banks. We distinguished cases where, as here, a general system of regulation might imply an affirmative decision to allow the behavior not specifically prohibited. 656 F.2d at 453 n.88. Thus Crocker did not narrow the general language in Adrisi. See id.

11. Provider claimed that these insureds could also buy prescriptions under their major medical plan. For those making numerous purchases of low-priced drugs, it could be cheaper to pay 20% of drug charges and the deductible, as the major medical required, rather than the copay charge of one or two dollars for every purchase under the pharmacy benefit. Association reads Provider's policy to prohibit those with the pharmacy benefit from getting prescription reimbursement under any other provision. This was a major issue throughout this litigation. Although we find Provider's reading of its contract fully credible, we are unwilling to reject Association's argument that the deductible amount was a sufficiently effective deterrent to prevent the major medical policy from being fully substitutable for the pharmacy benefit. as we find no merit in Association's claims, our decision does not turn on the question whether the major medical provisions further weakened Association's charges that the

pharmacy benefit created an "effective boycott" of its members.

12. Association's argument that Provider's nonexempt involvement with Pharmacy barred it from receiving the protection of the exemption for its other activities is frivolous. Were that the case, every insurer with a provider arrangement (as in Royal Drug) or consultative relationship with third-parties (as in Pireno) would forfeit all of its exemption from the antitrust laws. The business of noninsurance would overwhelm the business of insurance. There is no support for this position in law or logic.

13. The court first granted partial summary judgment under the McCarran-Ferguson Act for Provider on the tying claim only "for those violations which are based on a contract between Provider and its insureds." It left out any claim based on the contract between Provider and Pharmacy. It then amended its opinion, apparently to include the full tying claim in its disposition. See supra note 15. Yet in its final opinion the court went to the merits to decide that the provider agreement was not a tying agreement. As we find no support for a tying claim predicated on the provider agreement, we need not decide whether the court intended to dispose of it under the McCarran-Ferguson Act.

14. That the product determination hinges on market demand is perhaps clearest in the trademark cases. If consumers seek only the general services of the franchisees, a franchisor cannot

tie its trademark to purchase of component goods used in operating franchises. In this "business format" system, consumers "have no reason to associate with the trademark." Baskin-Robbins, 664 F.2d at 1353 (discussing Chicken Delight). Because franchisees can satisfy consumer demand by using "commonplace" items and applying the franchisor's general methods, coerced purchase of supplies from the franchisor forces consumers to pay for component products they don't really want. The coerced purchase of supplies thus can only have an anti-competitive motive. Id. In a "distributor" franchise, on the other hand, consumers are drawn to the franchise because its trademark indicates the availability of the franchisor's quality component products. "The franchised outlets serve merely as conduits through which the trademarked goods of the franchisor flow to the ultimate consumer." Id. To prevent the franchisor from forcing franchisees to use only company products would prevent consumers from effecting their market choices. The legality of the franchise arrangement thus turns on the court's perception of its place in consumer demand. See generally Hamro v. Shell Oil Co., 674 F.2d 784, 787-88 (9th Cir. 1982).

15. The district court first granted partial summary judgment against Association on the second (boycott) cause of action. It also granted summary judgment on the third (tying) cause of action, but only for violations based on the insurance contract, not those resting on the agreement between

Provider and Pharmacy. It amended its opinion to issue full judgment on the third cause of action and only partial summary judgment on the second. Nevertheless, in its final opinion the court decided on the merits those portions of both the second and third causes of action that rested on the agreement between Provider and Pharmacy. Our decision here does not turn on the scope of the McCarran-Ferguson exemption actually granted in the district court's earlier opinion.

16. This freedom extends to the manufacturer who for any lawful reason terminates one distributor or supplier and puts another in its place, even if the terminated businessman is put out of business. See Chandler Supply Co. v. GAF Corp., 650 F.2d 983, 989 (9th Cir. 1980); Las Vegas Sun, Inc. v. Summa Corp., 650 F.2d 614, 619-20 (9th Cir.), cert. denied, 447 U.S. 906 (1980); Bushie v. Stenocord Corp., 460 F.2d 116, 119 (9th Cir. 1972); Joseph E. Seagram & Sons, Inc. v. Hawaiian Oke & Liquors, Ltd., 416 F.2d 71, 76 (9th Cir. 1969), cert. denied, 396 U.S. 1062 (1970). It easily applies to the case at hand, where Provider did not drop an old associate, but merely decided not to initiate contracts with companies that would not deal with it on acceptable terms.

The Sherman Act

15 USC § 1. Trusts, etc., in restraint of trade illegal; penalty

Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal. Every person who shall make any contract or engage in any combination or conspiracy hereby declared to be illegal shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding one million dollars if a corporation, or, if any other person, one hundred thousand dollars or by imprisonment not exceeding three years, or by both said punishments, in the discretion of the court.

15 USC § 2. Monopolizing trade a felony; penalty

Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding one million dollars if a corporation, or, if any other person, one hundred thousand dollars or by imprisonment not exceeding three years, or by both said punishments, in the discretion of the court.

15 USC § 4. Jurisdiction of courts; duty of United States attorneys; procedure

The several district courts of the United States are invested with jurisdiction to prevent and restrain violations of sections 1 to 7 of this title; and it shall be the duty of the several United States attorneys, in their respective districts, under the direction of the Attorney General, to institute proceedings in equity to prevent and restrain such violations. Such proceedings may be by way of petition setting forth the case and praying that such violation shall be enjoined or otherwise prohibited. When the parties complained of shall have been duly notified of such petition the court shall proceed, as soon as may be, to the hearing and determination of the case; and pending such petition and before final decree, the court may at any time make such temporary restraining order or prohibition as shall be deemed just in the premises.

The Clayton Act

15 USC § 12. Words defined; short title

(a) "Antitrust laws," as used herein, includes the Act entitled "An Act to protect trade and commerce against unlawful restraints and monopolies," approved July second, eighteen hundred and ninety; sections seventy-three to seventy-seven, inclusive, of an Act entitled "An Act to reduce taxation, to provide revenue for the Government; and for other purposes," of August twenty-seventh, eighteen hundred and ninety-four; an Act entitled "An Act to amend sections seventy-three and seventy-six of the Act of August twenty-seventh, eighteen hundred and ninety-four, entitled 'An Act to reduce taxation, to provide revenue for the Government, and for other purposes,'" approved February twelfth, nineteen hundred and thirteen; and also this Act.

"Commerce," as used herein, means trade or commerce among the several States and with foreign nations, or between the District of Columbia or any Territory of the United States and any State, Territory, or foreign nation, or between any insular possessions or other places under the jurisdiction of the United States, or between any such possession or place and any State or Territory of the United States or the District of Columbia or any foreign nation, or within the District of Columbia or any Territory or any insular possession or other place under the

jurisdiction of the United States: Provided, That nothing in this Act contained shall apply to the Phillippine Islands.

The word "person" or "persons" wherever used in this Act shall be deemed to include corporations and associations existing under or authorized by the laws of either the United States, the laws of any of the Territories, the laws of any State, or the laws of any foreign country.

(b) This Act may be cited as the "Clayton Act".

15 USC § 14. Sale, etc., on agreement not to use goods of competitor

It shall be unlawful for any person engaged in commerce, in the course of such commerce, to lease or make a sale or contract for sale of goods, wares, merchandise, machinery, supplies, or other commodities, whether patented or unpatented, for use, consumption, or resale within the United States or any Territory thereof or the District of Columbia or any insular possession or other place under the jurisdiction of the United States, or fix a price charged therefor, or discount from, or rebate upon, such price, on the condition, agreement, or understanding that the lessee or purchaser thereof shall not use or deal in the goods, wares, merchandise, machinery, supplies, or other commodities of a competitor or competitors of the lessor or seller, where the effect of such lease, sale, or

contract for sale or such condition, agreement, or understanding may be to substantially lessen competition or tend to create a monopoly in any line of commerce.

15 USC § 15. Suits by persons injured--amount of recovery; prejudgment interest

(a) Except as provided in subsection (b) of this section, any person who shall be injured in his business or property by reason of anything forbidden in the antitrust laws may sue therefor in any district court of the United States in the district in which the defendant resides or is found or has an agent, without respect to the amount in controversy, and shall recover threefold the damages by him sustained, and the cost of suit, including a reasonable attorney's fee. The court may award under this section, pursuant to a motion by such person promptly made, simple interest on actual damages for the period beginning on the date of service of such person's pleading setting forth a claim under the antitrust laws and ending on the date of judgment, or for any shorter period therein, if the court finds that the award of such interest for such period is just in the circumstances. In determining whether an award of interest under this section for any period is just in the circumstances, the court shall consider only--

(1) whether such person or the opposing party, or either party's representative, made motions or

asserted claims or defenses so lacking in merit as to show that such party or representative acted intentionally for delay, or otherwise acted in bad faith;

(2) whether, in the course of the action involved, such person or the opposing party, or either party's representative, violated any applicable rule, statute, or court order providing for sanctions for dilatory behavior or otherwise providing for expeditious proceedings; and

(3) whether such person or the opposing party, or either party's representative, engaged in conduct primarily for the purpose of delaying the litigation or increasing the cost thereof.

Recovery by foreign states

(b)(1) Except as provided in paragraph (2), any person who is a foreign state may not recover under subsection (a) of this section an amount in excess of the actual damages sustained by it and the cost of suit, including a reasonable attorney's fee.

(2) Paragraph (1) shall not apply to a foreign state if--

(A) such foreign state would be denied, under section 1605(a)(2) of Title 28, immunity in a case in which the action is based upon a commercial activity, or an act, that is the subject matter of its claim under this section;

(B) such foreign state waives all defenses based upon or arising out of its status as a foreign state, to any claims brought against it in the same action;

(C) such foreign state engages primarily in commercial activities; and

(D) such foreign state does not function, with respect to the commercial activity, or the act, that is the subject matter of its claim under this section as a procurement entity for itself or for another foreign state.

Definitions: "commercial activity"; "foreign state"

(c) For purposes of this section--

(1) the term "commercial activity" shall have the meaning given in it section 1603(d) of Title 28, and

(2) the term "foreign state" shall have the meaning given it in section 1603(a) of Title 28.

15 USC § 22. District in which to sue corporation

Any suit, action, or proceeding under the antitrust laws against a corporation may be brought not only in the judicial district whereof it is an inhabitant, but also in any district

wherein it may be found or transacts business; and all process in such cases may be served in the district of which it is an inhabitant, or wherever it may be found.

15 USC § 26. Injunctive relief for private parties; exception

Any person, firm, corporation, or association shall be entitled to sue for and have injunctive relief, in any court of the United States having jurisdiction over the parties, against threatened loss or damage by a violation of the antitrust laws, including sections two, three, seven and eight of this act [15 USC §§ 13, 14, 18, and 19], when and under the same conditions and principles as injunctive relief against threatened conduct that will cause loss or damage is granted by courts of equity, under the rules governing such proceedings, and upon the execution of proper bond against damages for an injunction improvidently granted and a showing that the danger of irreparable loss or damage is immediate, a preliminary injunction may issue: Provided, That nothing herein contained shall be construed to entitle any person, firm, corporation, or association, except the United States, to bring suit in equity for injunctive relief against any common carrier subject to the provisions of the Act to regulate commerce, approved February fourth, eighteen hundred and eighty-seven [49 USC §§ 1 et seq.] in respect of any matter subject to the regulation, supervision, or other jurisdiction of the Interstate Commerce Commission. In any action under this

section in which the plaintiff substantially prevails, the court shall award the cost of suit, including a reasonable attorney's fee, to such plaintiff.

The McCarran-Ferguson Act

15 USC § 1011. Declaration of policy

Congress declares that the continued regulation and taxation by the several states of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.

15 USC § 1012. Regulation by State law; Federal law relating specifically to insurance; applicability of certain Federal laws after June 30, 1948

(a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

(a) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: Provided, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as

amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

15 USC § 1013. Suspension until June 30, 1948, of application of certain Federal laws; Sherman Antitrust Act applicable to agreements to, or acts of, boycott, coercion, or intimidation

(a) Until June 30, 1948, the Act of July 2, 1980, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, and the Act of June 19, 1936, known as the Robinson-Patman Anti-Discrimination Act, shall not apply to the business of insurance or to acts in the conduct thereof.

(b) Nothing contained in this chapter shall render the said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation.

App. J

The Oregon Podiatrists Statutes,
ORS 682.010

682.010 Definitions. As used in this chapter:

(1) "Board" means the State Board of Podiatry Examiners.

(2) "Podiatrist" means an individual who practices podiatry.

(3) "Podiatry" means the diagnosis or the medical, physical or surgical treatment of ailments of the human foot, except treatment involving the use of a general or spinal anesthetic unless the treatment performed in a hospital certified in the manner described in subsection (2) of ORS 441.055 and is under the supervision of or in collaboration with a physician licensed to practice medicine by the Board of Medical Examiners for the State of Oregon. "Podiatry" does not include the administration of general or spinal anesthetics or the amputation of the foot.

The Oregon Insurance Code
Insurance Policies Statutes,
ORS 743.006 and .009

743.006 Filing and approval of policy forms. (1) Except where otherwise provided by law, no basic policy form, or application form where written application is required and is to be made a part of the policy, or rider, indorsement or renewal certificate form shall be delivered or issued for delivery in this state until the form has been filed with and approved by the commissioner. This section does not apply to:

(a) Forms of unique character which are designed for and used with respect to insurance upon a particular risk or subject;

(b) Forms issued at the request of a particular life or health insurance policy owner or certificate holder and which relate to the manner of distribution of benefits or to the reservation of rights and benefits thereunder; or

(c) Forms of group life or health insurance policies, or both, which have been agreed upon as a result of negotiations between the policyholder and the insurer.

(2) The commissioner shall within 30 days after the filing of any such form approve or disapprove the form. The commissioner shall give

written notice of such action to the insurer proposing to deliver such form and when a form is disapproved the notice shall show wherein such form does not comply with the law.

(3) The 30-day period referred to in subsection (2) of this section may be extended by the commissioner for an additional period not to exceed 30 days if he gives written notice within the first 30-day period to the insurer proposing to deliver the form that he needs such additional time for the consideration of such form.

(4) The commissioner may at any time request an insurer to furnish him a copy of any form exempted under subsection (1) of this section.

743.009 Grounds for disapproval of policy forms. The commissioner shall disapprove any form requiring his approval:

(1) If he finds it does not comply with the law;

(2) If he finds it contains any provision, including statement of premium, or has any label, description of its contents, title, heading, backing or other indication of its provisions, which is unintelligible, uncertain, ambiguous or abstruse, or likely to mislead a person to whom the policy is offered, delivered or issued;

(3) If, in his judgment, its use would be prejudicial to the interests of the insurer's policyholders;

(4) If he finds it contains provisions which are unjust, unfair or inequitable;

(5) If he finds sales presentation material disapproved by him pursuant to ORS 743.021 is being used with respect to the form; or

(6) If, with respect to any of the following forms, he finds the benefits provided therein are not reasonable in relation to the premium charged:

(a) Individual health insurance policy forms subject to ORS 743.402 to 743.498, including benefit certificates issues by fraternal benefit societies;

(b) Health insurance policy forms issued by health care service contractors, except those forms issued under group health insurance coverages; or

(c) Credit life and credit health insurance forms subject to ORS 743.561 to 743.588.

The Oregon Insurance Code
Trade Practices Statutes
ORS 746.160

746.160 Practices injurious to free competition. Except as otherwise expressly provided by law, no person, either within or outside of this state, directly or indirectly, shall enter into any contract, understanding or combination with any insurer or manager, agent or representative thereof for the purpose of, nor shall any such persons or insurers, jointly or severally do any act or engage in any practice for the purpose of:

(1) Controlling the rates to be charged, or the commissions or other compensations to be paid, for insuring any risk or class of risks in this state;

(2) Discriminating against or differentiating from any insurer, manager or agent, by reason of its or his plan or method of transacting business or its or his affiliation or nonaffiliation with any board or association of insurers, managers, agents or representatives; or

(3) Doing anything which is detrimental to free competition in the business or injurious to the insuring public.

App. M

The Oregon Insurance Code
Health Care Service
Contractors Statutes,
ORS 750.005-.075

HEALTH CARE SERVICE CONTRACTORS

750.005 "Doctor," "health care service contractor" and "health care services" defined. (1) "Doctor" means any person lawfully licensed or authorized by statute to render any health care services.

(2) "Health care service contractor" means:

(a) Any corporation organized not for profit that is sponsored by or otherwise intimately connected with a group of doctors licensed by this state, or by a group of hospitals licensed by this state, or both, which accepts prepayment for health care services;

(b) Any person referred to in ORS 750.035; or

(c) Any corporation that accepts prepayment for ambulance and emergency medical service, or ambulance service only, but not for other health care services.

(3) "Health care services" means the furnishing of medicine, medical or surgical treatment, nursing, hospital service, ambulance service, dental service, optometrical service or any or all of the enumerated services or

any other necessary services of like character, whether or not contingent upon sickness or personal injury.

750.015 Management to include representatives of public. Not less than one-third of the group of persons vested with the management of the affairs of a health care service contractor, as defined in ORS 750.005(2)(a), shall be representatives of the public who are not practicing doctors or employes or trustees of a participant hospital.

750.025 Restricting distribution of income. No health care service contractor, as defined in ORS 750.005(2)(a), shall distribute, upon liquidation or otherwise, any part of its income to its members, directors, trustees or officers except for the reasonable value of services rendered such contractor.

750.035 Regulation of hospital care associations under prior law; exceptions. (1) Notwithstanding any other provision of law, except as provided in subsection (2) of this section, any persons doing a hospital association business, as defined in ORS 742.010 (1959 Replacement Part) in compliance with ORS chapter 742 (1959 Replacement Part) on August 12, 1965, may continue such business in compliance with ORS chapter 742 (1959 Replacement Part).

(2) Every person doing a hospital association business, as defined in ORS 742.010 (1959 Replacement Part), on August 12, 1965, shall comply

with the provisions of ORS 750.045 and the provisions of ORS 750.055.

750.045 Required capitalization; deposit of security. (1) A health care service contractor shall possess and thereafter maintain capital or surplus, or any combination thereof, of not less than $25,000 or an amount equal to 50 percent of the average claims incurred monthly during the preceding 12-month period, whichever is greater, but in no case shall the required amount be more than $500,000.

(2) The health care service contractor shall file a surety bond or such other bond or securities in the sum of $50,000 as are authorized by the Insurance Code as a guarantee of the due execution of the policies to be entered into by such contractor in accordance with ORS 750.005 to 750.065. This subsection does not apply to a health care service contractor that has at least 75 percent of its assets invested in health care service facilities pursuant to ORS 733.700.

750.055 Other provisions applicable to health care service contractors. (1) The following provisions of the Insurance Code shall apply to health care service contractors to the extent so applicable and not inconsistent with the express provisions of this chapter:

(a) ORS 731.004 to 731.150. 731.162, 731.204 to 731.362, 731.382, 731.386, 731.390, 371.398 to 371.430,

731.450, 731.454, 731.504, 731.508, 731.512, 731.574 to 731.620, 731.640 to 731.652, 731.804 and 731.844 to 731.992.

(b) ORS 732.230, 732.245, 732.250, 732.315 to 732.325 and 732.505 to 732.570.

(c) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.700 to 733.780.

(d) ORS chapter 734.

(e) ORS 743.003 to 743.012, 743.018 to 743.030, 743.037 to 743.108, 743.114, 743.116, 743.119 to 743.128, 743,350 to 743.370, 743.402, 743.412, 743.492, 743.495, 743.498, 743,527, 743,529, 743.549 to 743.558, 743,800 to 743.833 and 743.850 to 743.890.

(f) ORS 743.522 and 743.528, except that individual policies may be issued to the persons or families insured in lieu of issuance of a single group policy as referred to in ORS 743.522. An individual policy issued under this paragraph shall be considered the statement of the essential features of the insurance coverage required under ORS 743.528(2).

(g) ORS 744.005 to 744.265.

(h) ORS 746.005 to 746.140, 746.160, 746.180 and 746.220 to 746.370.

(i) ORS 743.135, except in the case of group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Public Health Service Act unless the patient is referred by a physician associated with a group practice health maintenance organization.

(2) For the purposes of this section only, health care service contractors shall be deemed insurers.

Note: The amendment to 750.055 by section 22, chapter 649, Oregon Laws 1981, takes effect January 1, 1983. See section 24, chapter 649, Oregon Laws 1981. 750.055, as amended, is set forth for the users' convenience.

750.055. (1) The following provisions of the Insurance Code shall apply to health care service contractors to the extent so applicable and not inconsistent with the express provisions of this chapter:

(a) ORS 731.004 to 731.150, 731.162, 731.204 to 731.362, 731.382, 731.386, 731.390, 731.398 to 731.430, 731.450, 731.454, 731.504, 731.508, 731.512, 731.574 to 731.620, 731.640 to 731.652, 731.804 and 731.844 to 731.992.

(b) ORS 732.230, 732.245, 732.250, 732.315 to 732.325 and 732.505 to 732.570.

(c) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.700 to 733.780.

(d) ORS chapter 734.

(e) ORS 743.003 to 743.012, 743.018 to 743.030, 743.037 to 743.108, 743.114, 743.116, 743.119 to 743.128, 743.350 to 743.370, 743.402, 743.412, 743.492, 743.495, 743.498, 743.527, 743.529, 743.549 to 743.558, 743.800 to 743.833 and 743.850 to 743.890.

(f) ORS 743.522 and 743.528, except that individual policies may be issued to the persons or families insured in lieu of issuance of a single group policy as referred to in ORS 743.522. An individual policy issued under this paragraph shall be considered the statement of the essential features of the insurance coverage required under ORS 743.528(2).

(g) ORS 744.005 to 744.265.

(h) ORS 746.005 to 746.140, 746.160, 746.180, 746.220 to 746.370 and 746.600 to 746.690.

(i) ORS 743.135, except in the case of group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Public Health Service Act unless the patient is referred by a physician associated with a group practice health maintenance organization.

(2) For the purposes of this section only, health care service contractors shall be deemed insurers.

Note: Section 5, chapter 319, Oregon Laws 1981, provides:

> Sec. 5. This Act does not affect a contract of insurance made before the effective date of this Act [November 1, 1981]. This Act applies to a renewal or extension of an existing contract of insurance made on or after the effective date of this Act as well as to a new contract of insurance made on or after the effective date of this Act.

750.059 Application of reimbursement requirement to group practice maintenance organizations for services by state hospital or state-approved program. ORS 743.116 does not apply to group practice maintenance organizations that are federally qualified pursuant to Title XIII of the Public Health Service Act (42 U.S.C. 300e et seq.).

750.065 Reimbursement for services performed by optometrists. (1) Notwithstanding any provision of contract or agreement entered into by a corporation, association, society, firm, partnership or individual doing business as a hospital association or as a health care service contractor, whenever such contract or agreement provides for reimbursement for any service which is within the lawful scope of practice of a duly licensed optometrist, the insured under such contract or agreement shall

be entitled to reimbursement for such service, whether the said service is performed by a physician or duly licensed optometrist. Unless such contract or agreement shall otherwise provide, there shall be no reimbursement for ophthalmic materials, lenses, spectacles, eyeglasses or appurtenances thereto.

(2) Nothing in subsection (1) of this section shall apply to any contract or agreement limited to the furnishing of services to be performed exclusively by members of the association, society, group or partnership issuing such contract or agreement.

750.075 Excess benefits contracts authorized for ambulance and emergency services contractors; notice to commissioner. Contracts issued by a health care service contractor described in ORS 750.005(2)(c) may provide that the benefits on behalf of the insured will be excess over benefits provided for the same service from other types of sources, if disclosure of this provision is adequately made, in the opinion of the commissioner, to the insured. All forms relating to such disclosure shall be filed with the commissioner and shall be subject to the procedures set forth in ORS 743.006 and 743.012.